

DEFENDING

AMERICA'S

SAFETY NET

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Emergency Physicians*

Defending America's Safety Net

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Defending America's Safety Net

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Editor's Note

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Wesley Fields, MD, FACEP

Executive Summary

Wesley Fields, MD, FACEP

Chair, Safety Net Task Force

ENVIRONMENTAL ANALYSIS

The nation's emergency departments and emergency physicians have evolved as the most visible and vital components of a patchwork of health care providers and facilities informally referred to as "the safety net." As Baxter and Mechanic of the Lewin Group have reported, "There is a long-standing notion in the United States, dating back to the nineteenth century, that we should maintain a health care safety net for persons who are uninsured, difficult to serve, discriminated against, or who cannot get care elsewhere."¹ The crucial role of EDs and emergency physicians as the providers of last resort became clear in 1986, when Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA).

As enforced by the Health Care Finance Administration (HCFA) and recently upheld by the United States Supreme Court, EMTALA is a civil right extended to all US residents. As a result, hospitals with EDs, emergency physicians, and the medical and surgical specialists who back them up are providers of the first health care benefit to be universally guaranteed by the US government. In practice, EMTALA is far more than a legal requirement on providers to perform emergency medical screening for outpatients in EDs. Because of the legal and ethical obligations of physicians and hospitals to stabilize life- and limb-threatening medical conditions they identify, EMTALA reasonably affords all US residents a guarantee of definitive hospital care for catastrophic illnesses and injuries. (In 1998, EMTALA was the largest federal health care program by default at 43 million because the uninsured were as well protected as those covered by private or government-sponsored

insurance plans.)

Unlike other federal health care programs, EMTALA is an unfunded mandate that falls unevenly on providers based on their willingness to staff or operate the nation's EDs, in particular rural and inner-city areas where the uninsured are found in disproportionate numbers. Implicit in EMTALA's enforcement by HCFA is the notion that services of safety net providers are cross-subsidized through the revenue they receive from other federal health care programs. Loss of Medicare provider status is the "death penalty" for egregious violations of the statute.

Because of the failure of the Clinton health care reform initiative, the 1990s have witnessed dramatic market-driven changes in the insurance and delivery systems. Although these changes began with employer-sponsored health care programs, they quickly spread to those sponsored by state and federal governments. The pressures on hospitals with EDs and the physicians that voluntarily staff them can be seen in a series of related trends during the decade.

Based on analysis of 16.4 million ED visits by the uninsured, the uncompensated costs to emergency physicians for services provided under EMTALA in 1996 is estimated at \$426 million. On a stand-alone basis, this amounts to the costs of staffing one out of every five EDs in the country. Extrapolation suggests that the uncompensated costs for inpatient services arising from EMTALA provided by hospitals the same year were in excess of \$10 billion. It would appear that the nation's EDs are the portal of entry for as many as three out of four uninsured patients admitted to US hospitals. If so, the vast

majority of the \$27 billion in uncompensated care provided by physicians and hospitals that the Congressional Budget Office estimated for 1995 can be linked directly to EMTALA.

Although these billions are a daunting sum for emergency physicians and the hospital EDs they staff, in terms of the trillion-dollar US health care sector the uncompensated costs for hospital-based services to the uninsured would appear to represent only 2.0% to 2.5% of annual expenditures. Thus, cross-subsidization of EMTALA-related services to the uninsured by other payer classes would not appear to be a principal driver of increasing US health care costs.

Between 1988 and 1996, ED patient visits rose from 81.3 to 93.1 million, an increase of 14%. During the same period, the number of EDs decreased from 5,210 to 4,740, with ED closures outstripping the rate of facility closures by 28%. Despite widespread disputes between managed care organizations (MCOs) and ED providers about the costs and medical necessity of emergency care, the average annual ED census increased 25.6%, from 15,600 in 1988 to 19,600 in 1996.

Although tens of millions of new jobs were created during this same period, the vast majority were among small employers, who were far less likely to offer health insurance to employees and their dependents. For many working families with low household incomes, employer-sponsored programs became less affordable. As a result, the number of working people with employer-sponsored health coverage dropped from 72% in 1988 to 58% in 1996. Eligibility for Medicaid in most states has contracted as a result of state and federal welfare reform. These factors were at work as the percentage of US residents under the age of 65 without health insurance rose from 15% to 18%.

Periods of ED saturation are increasingly common in many parts of the country. EDs also face mounting problems maintaining adequate back-up panel specialists, forcing many hospitals to choose between mandating coverage as a condition of medical staff membership or directly subsidizing professional care. HCFA has acknowledged that uncompensated care is a major component of practice expense for emergency physicians and remains to be accurately reflected in the resource-based relative value system (RBRVS).

The Safety Net Task Force believes that market conditions beyond our control are in direct conflict with both the mission of the American College of Emergency Physicians and EMTALA's mandate. Without intervention, the trends described above represent a clear and present danger to the integrity of the nation's delivery system for emergency medical care. On any given day, in any given community, regardless of ability to pay, US residents already lack timely access to quality care for acute illnesses and injuries. The Task Force recommends the following

initiatives for consideration by the College's Board and Council.

INITIATIVES

Local/Regional

To the extent that safety nets themselves vary substantially between rural and metropolitan service areas, short-term solutions to back-up panel problems and ED saturation are most likely to be driven by local initiatives.

Emergency medical service avenues and other health care agencies within local safety nets should affiliate within regional authorities that would allow them to coordinate the delivery of emergency care. Given the market-driven consolidation of medical transportation, hospital systems, and medical groups, safety net services can be realigned to incorporate the vertical and horizontal integration around them. This realignment might lead to more regionalization of certain emergency services within metropolitan areas. In rural areas it might lead to more comprehensive stabilization and transfer arrangements among facilities offering different levels of emergency and specialty care.

Without changes in current tax law and reimbursement mechanisms, hospitals will continue to have more flexibility than physicians in covering the costs of uncompensated care mandated by EMTALA. This flexibility is probably one reason for the trend toward direct employment of physicians by hospitals. Federal regulators should be asked to create a safe harbor for ED staffing and back-up panels from laws governing compensation arrangements between hospitals and members of their medical staffs whom they do not employ directly.

State Policy

In the absence of federal health care reform, most of the immediate opportunities to reduce the direct costs of uncompensated care for safety net providers exist at the state level. The approaches, however, are likely to be quite different for children and working adults under age 65.

Millions of children eligible for Medicaid are not enrolled. Millions from working families are now eligible for the Children's Health Insurance Program, passed as part of the Balanced Budget Act. Taken together, ACEP chapters have the immediate opportunity to support statewide efforts that would result in 90% to 95% of all pediatric patients in EDs having health insurance coverage.

Wherever states prove unwilling or unable to substantially expand health insurance to working adults, ACEP chapters should focus on legislative efforts that would establish safety net funds to reimburse providers for uncompensated care. Working models exist in Massachusetts for surcharges on health plan payments, in Minnesota for taxes on health care providers, and in California for taxes on vehicle code violators and tobacco

products. In all states that were party to the 1998 class action settlement with the tobacco industry, efforts should be made to ensure that the proceeds support safety net providers' ability to serve the uninsured.

Federal Policy

Given the current stalemate that exists in Washington and the low probability of fundamental health insurance reform, priority should be given at the federal level to reconciling the government's business practices as the largest purchaser of health care with the public policies embodied in EMTALA.

The College must maximize its efforts to ensure that the full costs of uncompensated care are incorporated into the practice expense formulas that determine physician compensation under the Resource-Based Relative Value Scale. This is the first step in an overall strategy intended to make the federal government accountable for the uncompensated care provided because of EMTALA.

Given the rapid conversion of Medicare (and Medicaid) to managed care, the gains related to incorporating uncompensated care costs into the Resource-Based Relative Value Scale must be protected from financial arbitrage by health plans contracting with HCFA under Medicare+Choice, or Part C. Thus the second step would focus on safety net services to beneficiaries of federal health care programs in MCOs provided by non-contracting providers. HCFA should stipulate in its contracts with health plans that "out-of-plan" safety net providers are reimbursed at *least* at the same rates they would receive for ED services rendered under Medicare Part B. The same principle should apply to safety net facilities for Part A fee schedules and the appropriate state Medicaid program for populations converted to MCOs. The net result is a floor for EMTALA-mandated services in Medicare/Medicaid MCOs equivalent to that in the traditional, cost-based programs, thus eliminating the opportunity for MCOs to discount payments to safety net providers that are not part of their networks.

Third, HCFA and state health care agencies responsible for Medicaid must be encouraged to implement a *safety net test*, which would preclude health plans from sub-contracting for emergency services with entities that cannot demonstrate that they either operate or staff EDs. This has the direct effect of removing one or more layers of fiscal intermediaries operating beyond the EMTALA mandate from receiving the portion of health care premiums earmarked for emergency services. The indirect effect, given the first two steps, is to encourage market-driven solutions to the problem of containing MCO costs for acute care that do not put safety net providers at a disadvantage.

The fourth step is to oppose the criminalization of attempts by safety net providers to cross-subsidize uncompensated costs. While supporting the efforts of the

Inspector General to prevent fraud and abuse among Medicare and Medicaid providers, emergency physicians and their billing agents who are audited or investigated for possible overpayments by HCFA should be given full credit for underpayments arising from downcoding unless there is evidence of systematic intent to defraud the government.

The fifth and final step in the federal strategy is for all changes in regulatory policies obtained for Medicare and Medicaid benefiting safety net providers to be extended to employer-sponsored programs as a prerequisite for waivers under the Employee Retirement Income Security Act (ERISA). Although this would probably require statutory change, it would have leverage gains achieved because of the EMTALA mandate to other payer classes.

EXPANDING HEALTH CARE INSURANCE COVERAGE FOR WORKING PEOPLE

Universal health insurance coverage remains the ultimate goal of safety net providers and their patients. Given the diverse nature of the uninsured population, it is unlikely that significant progress can be made without a series of linked incremental reforms that do not undermine employer-sponsored programs. ACEP should consider direct participation in advocacy groups such as the National Coalition on Health Care, which support the following:

- Safety net stewardship through cost containment within our own service sector in order for health insurance to be more affordable for working people of lower income.
- Expansion of the current deductibility of health insurance premiums to allow tax credits for lower-income individuals to be used for the purchase of health insurance.
- Expansion of direct subsidy programs for state purchasing pools for working people without access to employer-sponsored health insurance.
- Expansion of Medicaid eligibility to include all US residents with household incomes below the federal poverty level.

EQUALIZATION OF STATE AND FEDERAL TAX POLICY

The vast majority of hospitals operate on a nonprofit basis that exempts them from state and federal income taxes. The IRS has held that the operation of an ED is the most important test to determine whether facilities are providing the community benefit required to maintain their exempt status. Even for-profit hospitals are allowed to deduct the direct costs of uncompensated care from their taxable revenue.

Physicians could be expected to be more willing to provide safety net services if some of the benefits afforded facilities were extended to professionals not employed by hospitals. The direct professional costs of uncompensated care could be made deductible from federal income taxes to

provide an offset for services provided arising from the EMTALA mandate.

Charitable trusts arising from the conversion of hospitals (and health plans) from nonprofit to for-profit status should be used only for safety net services and/or expansion of health insurance coverage. Some states already have laws in this regard. Given that EMTALA is a federal mandate and the existing IRS emphasis on EDs for nonprofit hospitals, a federal standard for such charitable trusts would seem reasonable.

State or federal taxes intended to offset uncompensated costs could selectively target sectors of the health care industry whose profitability is determined, in part, by their ability to operate beyond EMTALA's requirement to deliver services without regard to the patient's ability to pay. Alternatively, state or federal tax revenues intended to expand health care coverage could be raised through

reduction in the current level of health care benefits deductible for employers and their employees. Although obviously controversial, such a debate could begin with social recognition of the fact that EMTALA constitutes catastrophic (not comprehensive) health care coverage for all US residents.

The problems arising from EMTALA beg the most fundamental and politically dangerous question not currently addressed in America. Should working people under the age of 65 without health insurance be forced to pay income and payroll taxes that support employer and government-sponsored health care programs for those more affluent than themselves?

Reference

1. Baxter RJ and Mechanic RE, "The Status of Local Health Care Safety Nets," *Health Affairs*, July/August 1997;16:4:7-23.

Defining America's Safety Net

Wesley Fields, MD, FACEP

Chair, Safety Net Task Force

INTRODUCTION

Most, if not all, emergency physicians would agree that their primary goal is to provide quality emergency medical care. This is the stated reason for the existence of the American College of Emergency Physicians.¹ By their nature, acute illnesses and injuries are episodic and largely self-defined by the 100 million individuals who visit the nation's emergency departments annually. EDs serve as the hubs of regional systems of prehospital emergency medical services. In addition to providing medical direction to EMS systems, emergency physicians also helped to develop the hospital-based specialty services upon which all US residents have come to rely for trauma care, cardiac care, burn care, and poison control. But the ability of emergency physicians to fulfill their primary mission of providing quality emergency medical care to all who seek it is increasingly threatened by a secondary mission that society has thrust upon them by default.

The nation's EDs have evolved as the most visible and vital components of a patchwork of health care providers informally referred to as the "safety net." As Baxter and Mechanic of the Lewin Group have reported, "there is a long-standing notion in the United States, dating back to the nineteenth century, that we should maintain a health care safety net for persons who are uninsured, difficult to serve, discriminated against, or who cannot get care elsewhere."² In recent years, the popular media and health care analysts have helped to firmly identify the ED with many of the at-risk populations emergency physicians recognize as among their most needy patients.³ These include mothers and infants without access to maternal or

child health services, the chronically ill and disabled, persons with AIDS, the mentally ill or gravely disabled, alcohol and drug abusers, the suicidal and homicidal, victims of domestic violence, the homeless, and recent immigrants. Indeed, much of what makes emergency medicine a unique body of knowledge encompasses the special training and skills necessary to effectively evaluate and treat many of these individuals and their medical conditions.

In the absence of fundamental health care reform, the widespread perception of emergency departments as safety net facilities is that the problem of uncompensated emergency care has dramatically worsened since the 1987 ACEP policy statement on the subject.⁴ At issue is whether the market-driven changes in the rest of the health care delivery system represent a threat to the ability of emergency physicians and the hospitals where they practice to provide quality emergency medical care to all US residents. For this reason, ACEP President John Moorhead, MD, created a Safety Net Task Force in 1998. The specific goals identified during the first meeting of the Task Force during the Scientific Assembly in San Diego included:

- Assessing the scope of the problem in terms of the number of ED visits by the medically indigent and the direct costs to safety net providers, including medical specialists serving on ED back-up panels and facility costs for outpatient and inpatient care.
- Evaluating evidence that reductions in the number of ED visits and reimbursement associated with managed care organizations (MCOs) has accelerated ED closures and reductions in service levels.

- Determining whether these trends represent a current or future threat to public safety for all US residents.
- Reporting back to the 1999 ACEP Council on the overall condition of safety net facilities, including strategic policy initiatives for the consideration of the College.

DEFINING THE SAFETY NET

The Institute for the Future, in a study of California's health care system, described the public safety net as "the providers of last resort." These safety net providers include nonprofit clinics that are often operated by local governments in conjunction with public hospitals. But the bulk of the acute ambulatory and inpatient care is provided elsewhere by community and district hospitals, university medical centers, and other government hospitals. The professionals include nurse practitioners and physician assistants, salaried physicians engaged in postgraduate training and their faculty, as well as physicians in private practice. The precise definition of a safety net provider became a matter of controversy in many states with the migration of the fee-for-service Medicaid program to managed care models during this decade. State and federal government officials, hoping for the same early success in controlling costs reported in the private sector with conversion of indemnity health care programs to MCOs, often contemplated contracting directly with the same commercial plans. Most such private networks scrupulously avoided traditional safety net facilities and providers because of their inherent lack of cost-effectiveness. In many communities, the political influence of safety net providers allowed them to remain competitive with commercial plans in negotiations with directors of state Medicaid programs and legislators. In many cases, state policy makers chose to remain deliberately vague about the amount of charity or uncompensated care providers must demonstrate in order to qualify for safety net status in Medicaid managed care contracting.

A rigorous safety net definition would be limited to health care entities that include charity care in their charter and those facilities and professionals having statutory requirements to provide health care to the medically indigent. Approximately half of all states have laws requiring counties to provide care to the medically indigent. For EDs in all states, and the physicians that staff them, the federal mandate is clear. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals contracting with Medicare (and their staff physicians) provide the full scope of the services available in their facilities to all individuals seeking evaluation and treatment of emergency medical conditions, without respect to their ability to pay. Further, EMTALA states that individuals cannot be discharged home until sufficient evaluation and treatment have determined that no material deterioration in their condition will occur before they receive medically

necessary care as outpatients. Patients who remain unstable for discharge home following ED care are either admitted to the community facility where they presented or transferred to a public hospital within the same jurisdiction, depending on the patient's stability for transfer under EMTALA and the availability of appropriate care in the receiving facility. The federal anti-dumping law was recently expanded in scope by the United States Supreme Court to include hospital inpatients discharged or transferred prematurely, even in the absence of intent to discriminate against the patient for financial reasons.⁵ A recent notice published in the Federal Register made it clear that the Health Care Finance Administration (HCFA) also intends to enforce the anti-dumping law as it relates to emergency services provided to members of MCOs.

DEMOGRAPHICS OF THE UNINSURED

The United States Census Bureau reported that 43.4 million US residents had no health insurance in 1997, nearly one in five people under the age of 65. This represented an increase of 1.7 million from the year before⁶, in keeping with the steady trend observed since 1987, when only 15% were uninsured. One in three US residents had been uninsured for at least one month in the two years prior to 1997.⁷ The number without health insurance is projected to reach 20%, or 57.1 million, by 2005.⁸

Sixty percent of the uninsured are working adults, with their dependents making up another 20% (between the ages of 19 and 39). The typical profile of the person most likely to be without health insurance is an adult with children, whose household income is between \$20,000 and \$50,000.⁹ They work without benefits, either because their

Table I.
Type of Health Insurance and Coverage Status in 1997 (in thousands)

	Number	%
ALL PERSONS		
Total.....	269,094	100.0
Total covered.....	225,646	83.9
Private.....	188,533	70.1
Employment-based.....	165,092	61.4
Government.....	66,685	24.8
Medicare.....	35,590	13.2
Medicaid.....	28,956	10.8
Military.....	8,527	3.2
Not covered.....	43,448	16.1
POOR PERSONS		
Total.....	35,574	100.0
Not covered.....	11,238	31.6

Note: The estimates by type of coverage are not mutually exclusive; in other words, persons can be covered by more than one type of health insurance during the year.

SOURCE: U.S. Census Bureau, March 1998 Current Population Survey.

employers do not offer them or because they feel unable to afford the ever-expanding share of medical costs that employees must bear. According to Census Bureau data, 75% are Hispanic, black, or Asian; 44.5% have a high school education or less. They are most likely to be found working in service industries, especially restaurants, or one of the construction trades. The working poor were twice as likely than the general population to be uninsured (31.6% in 1997 Census Bureau reports).

DECLINING ENROLLMENT IN EMPLOYER-SPONSORED HEALTH PLANS

There is general agreement that the proportion of working Americans covered by employer-sponsored health plans has declined over the last decade. The Employee Benefits Research Institute reported a decline from 69.5% in 1988 to 63.8% in 1995. A recent UCLA study reported that almost all firms with more than 25 employees continue to offer health care benefits to their employees. Although smaller firms continue to be less likely to do so, the proportion of those offering benefits increased between 1989 and 1996. Among those with less than nine employees, the rate rose from 43% to 51%. Among those with 10 to 24 employees, the rate rose from 72% to 78%. The number of employees voluntarily enrolling in employer-sponsored programs dropped 7% during the study period. A multivariate analysis revealed that the reasons most likely to be given by employees included increased share of costs for benefits, decreased access to health plans with choice of providers, greater exclusions of pre-existing conditions, long waiting times for eligibility, and less coverage of temporary workers.¹⁰

Because the cost of health care is less predictable for small pools of employees than for large pools, smaller firms continue to find fewer health insurers willing to underwrite their benefits and higher premiums for the same coverage offered larger firms. In a General Accounting Office study, small firms also cited higher administrative costs, more

frequent employee turnover and lower profitability as reasons for not offering health care benefits.¹¹ That 21 million of 22 million new jobs created in the United States between 1988 and 1995 were in companies with fewer than 100 employees is one of the principal drivers of the decrease in work-related health insurance. Only 40% of employees of firms with less than 100 workers were likely to have health insurance,¹² as opposed to 83% among employees of firms with more than 100 workers.

THE SAFETY NET AS A DELIVERY SYSTEM

Although safety nets are by nature local or regional in structure, a general understanding of the nation's delivery system of last resort can be culled from the American Hospital Association's (AHA) Annual Survey. In 1994, uncompensated care averaged 6.1% of expenses for the 5,229 non-federal, short-term, general hospitals reporting. When an analyst sorted hospitals by the percentage of uncompensated care they provided, patterns began to emerge.¹³ The top decile provided 15% of all uncompensated care, nearly twice that of the next decile. Not surprisingly, such facilities also reported the lowest operating margins (1% versus the national average of 3%) and the largest percentage with negative operating margins (34% of all hospitals within the top decile). The top decile was two to three times more likely to be found in the Southeast or Middle South. This decile was also more than twice as likely to consist of public hospitals owned either by city or county governments or local hospital districts (50% versus 22% for all other deciles). Only 55% of all hospitals providing the most uncompensated care were to be found within AHA metropolitan statistical areas, with the next largest percentage (22%) being rural hospitals with fewer than 50 beds. Overall, 45% of the hospitals in the top decile of uncompensated care were rural facilities.

In the same study from the Association of American Medical Colleges, the relationship between graduate medical education and uncompensated care was explored. Only one fifth of the AHA survey hospitals had

Table 2.
Workers Covered by Their Own Employment-Based Health Insurance, by Firm Size: 1997 (in thousands.)

	Total	Number	%
ALL WORKERS	144,582.....	76,569	53.0
FIRM SIZE			
<25 employees.....	42,394.....	12,049	28.4
25 to 99 employees.....	18,374.....	9,628	52.4
100 to 499 employees.....	19,051.....	11,775	61.8
500 to 999 employees.....	8,091.....	5,395	66.7
>1,000 employees.....	56,671.....	37,723	66.6

SOURCE: U.S. Census Bureau, March 1998 Current Population Survey.

Table 3.
Persons Without Health Insurance by Household Income: 1997 (in thousands.)

	Uninsured		
	Total	Number	%
ALL PERSONS	269,094.....	43,448	16.1
INCOME			
Less than \$25,000.....	72,219.....	18,361	25.4
\$25,000-\$49,999.....	80,361.....	14,527	18.1
\$50,000-\$74,999.....	56,169.....	5,678	10.1
\$75,000 or more.....	60,346.....	4,882	8.1

SOURCE: U.S. Census Bureau, March 1998 Current Population Survey.

postgraduate residents (1,010 facilities). Of these, approximately 200 hospitals were responsible for 54% of all US residency-training positions. Unlike the distribution of hospitals providing the largest amounts of uncompensated care in the South/Southeast, the top decile of hospitals involved in graduate medical education were concentrated in the Northeast, Middle Atlantic, and Great Lakes regions. New York City alone was responsible for 12% of all US medical residents. Thirty-three hospitals were found in the top deciles for both uncompensated care and graduate medical education; of these, 85% were owned by city, county, or state governments in conjunction with university medical centers. Unlike public hospitals without graduate medical education, the top teaching facilities tended to have better average operating margins. This would support the notion that the uncompensated care burden was partially offset by the ability of some tertiary facilities to cross-subsidize charity care through medical research funding and better third-party reimbursement associated with their status as regional referral centers.

For the other nine deciles of safety net facilities that provided 85% of all uncompensated care in 1994, the overall picture is very different. Seventy-seven percent are private community facilities, although the vast majority enjoy nonprofit status, including many faith-based organizations. Eighty percent operate without residents engaged in graduate medical education who provide professional services to the uninsured. Eighty-two percent are to be found outside the nation's 100 largest cities. Thus the perception that the urgent need for sophisticated hospital care among the uninsured occurs within easy reach of public hospitals and eager postgraduate residents is only an illusion shared by viewers of the popular television series *ER* and many health care policy makers.

CHANGES IN SAFETY NET ECONOMICS IN THE MANAGED CARE ERA

In a related analysis, AHA Annual Survey trends between 1983 and 1995 were studied to assess the impact of managed care penetration on safety net facilities.¹⁴ As the authors from RAND noted in their introduction:

Hospitals have been able to fund (\$17.5 billion in uncompensated care in 1995) through a delicate balance of internal and external cross-subsidies... In a few states these cross-subsidies are made explicit through uncompensated care trust funds as part of all-payer hospital rate-setting programs or through the establishment of indigent care subsidies that offset some of the costs of charity care. Explicit recognition of the burden shouldered by subsets of providers is also acknowledged in both Medicare and Medicaid through separate disproportionate-share hospital (DSH) payment policies. In most places, however, the cross-subsidies remain largely hidden... There is growing concern that

the system of subsidies that has preserved the safety net is rapidly eroding because of managed care growth and price competition, tightening of fiscal pressures begun under Medicare's fixed-price payment system (DRGs), and growth in the number of uninsured persons.

Diagnosis-Related Groups (or DRGs) provided the first clear evidence of the chilling effect on hospitals to continue to provide charity care when payers forced them to abandon cost-based reimbursement for the prospective methods of reimbursement associated with managed care. The Prospective Payment Assessment Commission evaluation of the impact of diagnosis-related groups revealed that, between 1992 and 1994, hospitals facing the most pressure from private payers greatly reduced their uncompensated care load.¹⁵ The RAND analysts offered several conclusions in the study after adjusting for inflation and related changes in hospitals costs between 1983 and 1995:

- The increase in uncompensated care after 1988 appears not to have kept up with growth in hospital expenses or the uninsured population, although declines in the relative level of effort were modest and did not suggest a large-scale reduction of effort. This was underscored by the fact that urban public hospitals saw no increase in their relative share of uncompensated care of 15%, yet experienced an increase of 21% in the percentage of total hospital expenses attributed to uncompensated care. This suggests an erosion of their revenue base from other payer classes.
- Hospitals serving a large share of the Medicaid population experienced increases in uncompensated care relative to hospitals with low Medicaid load (from 46% to 56% during the study period) with the result that the top third of Medicaid facilities provided half of all uncompensated care nationally.
- Hospitals that experienced financial losses from Medicare reduced uncompensated care levels relative to hospitals with financial gains under diagnosis-related groups, despite the increase in the percentage of uninsured patients during the study period. This phenomenon was most true in metropolitan service areas with higher levels of competition between hospitals, which also tended to be the areas with the largest percentage of uninsured patients, as well as the highest levels of managed care penetration.

The willingness of community hospitals to provide uncompensated care when managed care achieves high market share is now a major concern among California's safety net providers. The disjunction between charity care and Medicaid services was observed in a recent study from the public advocacy group, Health Access,¹⁶ which revealed that six of thirteen safety net facilities in the Bay Area

receiving disproportionate-share revenue from Medicaid were providing less than 1.7% of hospital services as charity care. This is dramatically less than the national average for all hospitals in the AHA Annual Surveys. That this occurred in a market with nearly 50% HMO penetration suggests that the price elasticity of the fee-for-service era that allowed community facilities to perform safety net functions is largely eliminated by MCOs' efforts to control their own costs.

The economic stress on California's safety net facilities has been further evidenced by the shift of the state Medicaid program to the Two-Plan Model of Managed Medi-Cal. One of the structural elements of implementing this approach in the 12 California counties where it is being deployed is the notion of balancing enrollment in both Commercial Plans and Local Initiatives (made up of traditional safety net providers) to promote competition and choice. San Francisco and Contra Costa Counties, both of who operate public hospitals, have requested federal waivers, which will allow them to operate Local Initiative Plans only. This is in large part because projections showed that the number of eligible Medi-Cal beneficiaries was significantly less than the 60,000 expected for both plans to be economically viable. Bay Area Congresswoman Nancy Pelosi was expected to sponsor such federal waivers with the full support of the for-profit Commercial Plan Foundation, appointed by the state for both counties. The concept of concentrating Medi-Cal Managed Care beneficiaries in public safety net facilities has proven successful in other single-plan counties in Northern California, most notably San Mateo and Solano, where single integrated delivery systems for health care have served both patients and providers efficiently and produced strong economic results.

The potential impact on trauma care when safety net facilities fail was dramatized in 1995-1996, when Los Angeles County/University of Southern California Medical Center came within days of closure before a \$186 million bailout in federal funds.¹⁷ In a *JAMA* editorial from a USC faculty member, a strong argument was made for why the crisis was not an aberration unique to a county with a budget larger than 42 states, but a harbinger of the future for safety net facilities in large and small:

The population continues to grow as the arithmetic sum of major Euro-American flight immigration dominated by the Pacific Rim countries, and a substantial birth rate, particularly among newly arrived groups. In 1994 there were 220,000 employers in Los Angeles County and 200,000 of those employed fewer than 50 employees. Since small employers are far less likely to provide work-related health care insurance, the county currently experiences a 30% rate of medically uninsured (compared with a US rate of 17%). In the population older than 65 years, the rate of uninsured is about 5%

(compared with a US average of 1%), largely because of the immigration of non-citizens who have not become eligible for Medicare.

The other unique factor is the rapid penetration of managed care as the primary form of health care insurance...95% of commercial...insurance is managed care, and 50% of that is in (HMOs). Nearly 40% of the Medicare population is in managed care, and over 25%, soon to be 75%, of the (Medi-Cal) population is in managed care plans.

...Because both state and federal law require evaluation of those who seek care in (EDs)...trauma centers...are now experiencing as much as 40% uncompensated care. These financial pressures...have led to a decrease in the total number of hospital-based (EDs) from 103 in 1985 to 85 today...Certified trauma centers have decreased from 3 publicly operated and 20 private centers in 1983 to 3 public and only 10 private centers today.

...The critical question relevant to all of this is how to keep essential emergency services operating when the major beneficiaries (numerically) are less likely to vote or to influence elections. The rest of the public, who do vote and influence elections, do not perceive the existence of a problem and are overwhelmed with their priorities for funding police, courts, and jails. Nor are they likely to recognize this very real hazard until a catastrophe results in a clear demonstration of their own vulnerability...

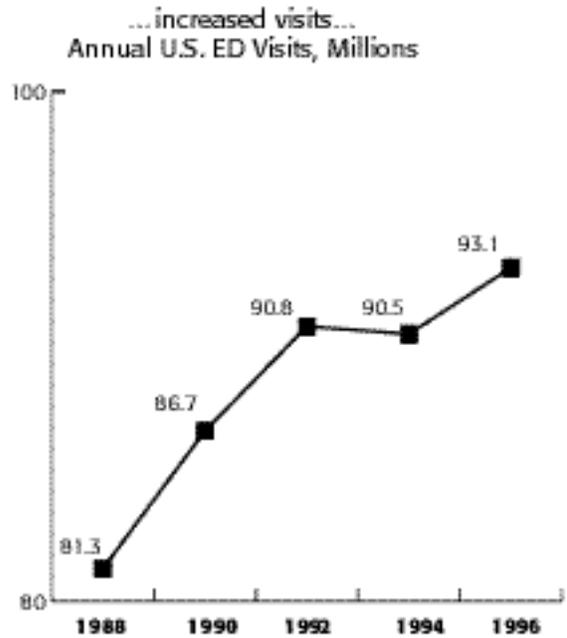
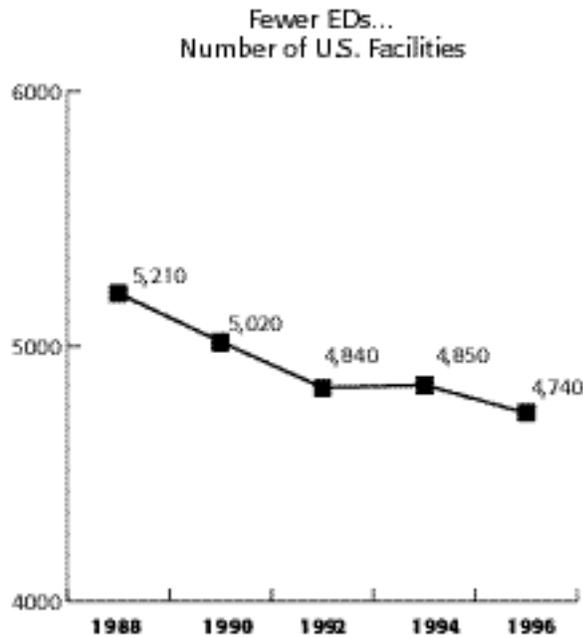
One part of the solution that would seem wise, at least for the time being, is to continue to have local government play a major irreplaceable role in the coordination and provision of emergency and trauma care for the entire population...As long as these services are critical to the entire population, they will continue to receive a level of local political support. And as the former Speaker of the House of Representatives (Tip) O'Neill has reminded us, all politics is local.¹⁸

UTILIZATION OF THE NATION'S EDs

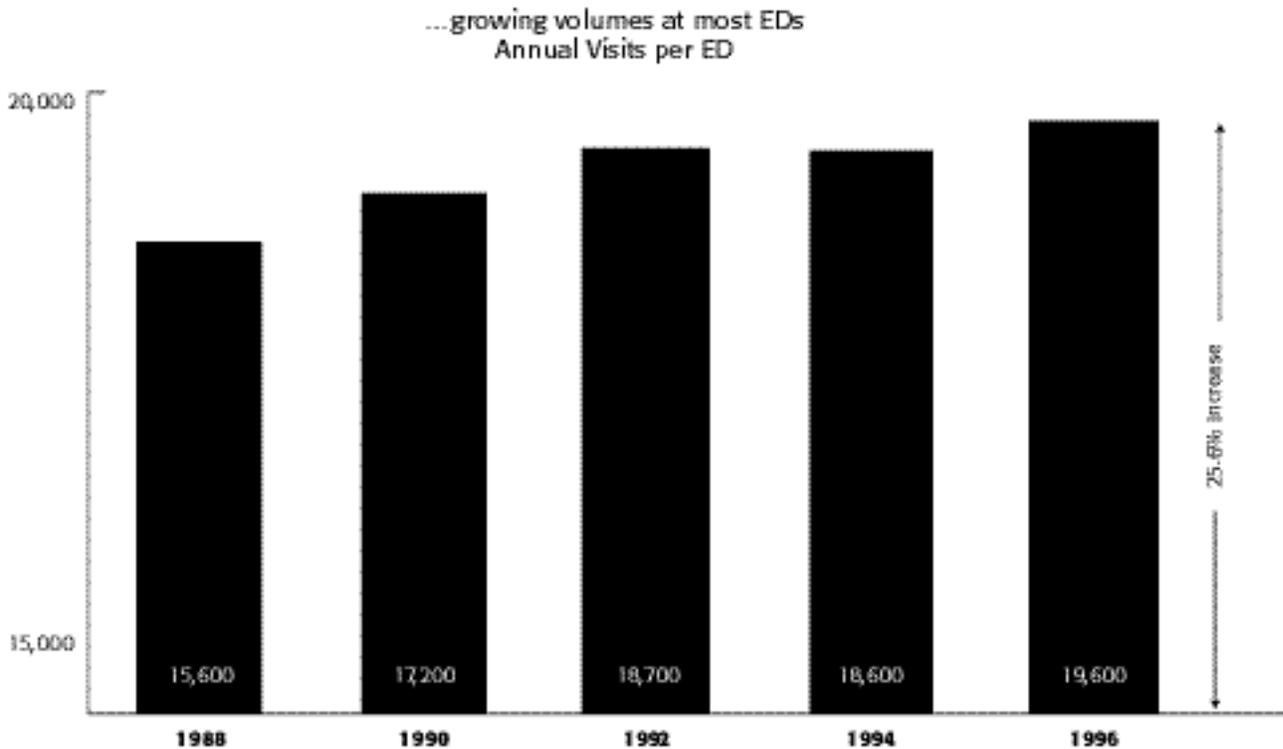
According to the AHA, between 1988 and 1996, the number of hospitals declined 7%, from 5,230 to 5,130. The number of hospitals with EDs declined at an even faster rate, 9%, from 5,210 to 4,740. This was not the result of a decrease in demand for ED services, however. During the same period, the number of ED visits increased 14%, from 81.3 million to 93.1 million. As a result of these two paradoxical trends, the average annual ED volume climbed 25.6% between 1988 and 1996, from 15,600 visits to 19,600 visits. As the Advisory Board consulting firm noted in reporting these trends to subscribing members, "it doesn't take a rocket scientist" to understand why delays in ED treatment and facility saturation have become commonplace during the managed care era.¹⁹

It Doesn't Take a Rocket Scientist

A Simple Calculus



A Singular Impact



MODELING THE DIRECT COSTS OF ED CARE FOR THE UNINSURED

In 1996, the AHA reported 97 million ED visits.²⁰ For the same year, the National Center for Health Statistics (NCHS) reported that 16.8% of all ED patients were uninsured.²¹ Taken together, AHA and NCHS data suggest that the uninsured were responsible for 16.4 million ED visits in 1996. This figure is somewhat higher than might be expected on a per capita basis from Census Bureau data, which indicates that only 15.6% of the US population was uninsured in 1996. It is no surprise to safety net providers that the uninsured are more likely than the rest of the population to seek acute care services. However, the AHA/NCHS estimate does not support the widely held opinion that the uninsured have a significantly higher pattern of ED utilization than beneficiaries of other payer classes. The NCHS reported in 1996 that the US population had 342 ED visits per thousand annually; the AHA/NCHS estimate for the uninsured equated to 393 per thousand. Actuarial data from Milliman and Robertson during the same period suggested a range for Medicaid populations from 300 to 600 ED visits per thousand.²² Thus, the AHA/NCHS estimate falls in the lower half of the range one would predict if utilization by uninsured mirrored that of the medically indigent beneficiaries of Medicaid.

The 1997 ACEP workforce study prospectively evaluated the ED staffing of 942 hospitals representing a stratified cross-sectional sample of all hospitals in the 1995 data base of the AHA.²³ The annualized ED visits of the hospital EDs studied was 18.7 million, a number strikingly, if coincidentally, like the projected ED utilization by the uninsured in 1996 (16.4 million). More importantly, the ACEP workforce study methodology can be shown to represent a statistically valid cross-sectional, stratified sample of all AHA hospitals with EDs in 1997. Some, if not all, of the costs of ED care for the uninsured can be reasonably extrapolated from the ACEP workforce study for the purposes of this discussion.

Based on the observed average of 40 clinical hours per week for full-time emergency physicians, the ACEP study concluded that 3,889 full-time equivalents were required to provide emergency medical screening and stabilization to the 18.7 million patients seen in 1997 in the sampled 942 EDs. An eight-survey average for emergency physician compensation during the same period, including sources

such as the American Medical Group Management Association and the accounting firm Ernst & Young LLP, suggests that each full-time equivalent would receive \$179,294 in annual compensation.²⁴ For the total ACEP population receiving emergency physician services, the 3,889 full-time equivalent would amount to \$697,274,366. From this, one might estimate an average emergency physician cost of \$37,287,399 per million patient visits, or \$37.20 per visit. If this is applied to the estimated number of 1996 ED visits by the uninsured, the direct emergency physician costs would be \$609,660,979.20.

As a payer class, the Congressional Budget Office (CBO) opined in 1995 that the uninsured could be expected to pay for 30% of the direct costs of their hospital care.²⁵ On the basis of usual and customary charges rather than direct emergency physician staffing costs, most billing agents for emergency medical groups would suggest that the CBO estimate is exponentially inflated. For the sake of this discussion, however, we will bow to the authority of the CBO in analyzing the costs of the EMTALA mandate. Working Americans without health care insurance therefore could be expected to pay one third of the emergency physician staffing costs for their care in EDs, or approximately \$183 million in 1996. The remaining amount, \$426 million, represents the estimated amount of uncompensated care provided by members of ACEP and other emergency physicians in 1996. In the managed care era, this amount also can be quantified as the disputed value of professional emergency services. Fractions of this sum have been the object of increasingly contentious contract negotiations and retrospective claims disputes between emergency physicians and representatives of other payer classes. Not surprisingly, third parties operating beyond the EMTALA mandate on safety net providers have been unwilling to cross-subsidize the costs of emergency care for the uninsured at the expense of their own business goals.

Table 4.
Uninsured ED Visits for 1996

Total Number of ED Visits.....	97,552,005
US Census Without Health Insurance	15.60%
ED Patients Without Health Insurance.....	16.80%
Estimated ED Visits by Uninsured.....	16,388,736

Table 5.
Emergency Physician Costs for ED Care of Uninsured in 1996

Estimated ED Visits by Uninsured.....	16,388,736
Estimated Emergency Physician Cost per Visit.....	\$37.20
Total Emergency Physician Costs for Uninsured.....	\$609,660,979.20
Estimated Payment Ratio Uninsured.....	0.3
Estimated Total Emergency Physician Payments.....	\$182,898,293.76
Estimated Uncompensated Emergency Physician Care.....	\$426,762,685.44

To the extent that EMTALA reasonably assures that individuals with life-threatening conditions receive the full benefit of hospital care until they are stable for discharge home, the full costs of the EMTALA mandate extend far beyond ED care. This can be inferred from the fact that 16.2% of ED patients were admitted to the hospital from the 942 EDs in the ACEP workforce study, including 3.6% to critical care units. One might argue that the ACEP study admission percentages are skewed higher because they include patients over age 65, who ordinarily qualify for Medicare benefits, unlike the vast majority of the uninsured. This may be offset by the fact that the uninsured typically defer continuing care, leading to higher costs during hospitalizations, and admission rates twice those of the insured for complications of chronic disease states.²⁶

For the sake of this pro forma, the ACEP study might be used to suggest that in 1996 the uninsured were responsible for a total of 2.6 million hospitalizations. This would not seem unreasonable given NCHS data confirming a total of 30.7 million hospital discharges for the same period,²⁷ or slightly more than half of what would be predicted on a per capita basis alone for 15.6% of the US population (8.6% of all hospital discharges). Although the direct costs are difficult to estimate from extrapolated data, an approximation can be made from a 1987 analysis by the Agency for Health Policy and Research which found that the uninsured received \$5,679 in care per hospitalization (108% of the average for insured patients). Without cost adjustments for the period between 1987 and 1995, when costs were rising rapidly in the absence of managed care penetration in many markets, the 2.6 million uninsured admissions projected from the ACEP workforce study would have been expected to cost \$15.1 billion, including

Table 6.

Hospital Costs for Uninsured Admissions Through the ED in 1996

Estimated ED Visits by Uninsured.....	16,388,736
Admission Ratio Through the ED.....	0.162
Estimated Uninsured Hospitalizations.....	2,654,975.232
Average Hospitalization Cost.....	\$5,679.00
Estimated Uninsured Hospital Costs.....	\$15,077,604,342.53
Estimated Payment Ratio Uninsured.....	0.30
Estimated Total Hospital Payments.....	\$4,523,281,302.76
Estimated Uncompensated Hospital Care.....	\$10,554,323,039.77

\$10.5 billion in uncompensated care.

That the nation's EDs have become the portal of entry into hospital-based care for the vast majority of the uninsured is supported by a comparison of our 1996 hospital cost projection and a direct analysis of the CBO. The CBO estimated that in 1991 the uninsured received \$15.2 billion in uncompensated hospital care. Based on their cost projections and assumptions regarding payments from uninsured patients, the total costs of hospital care were expected to reach \$21.5 billion by 1995. Thus the nation's emergency physicians - and the ED back-up panel specialists who provide inpatient care until patients admitted through the ED are stable for discharge home - appear to be responsible for three out of every four cases in which patients are admitted without health insurance. The CBO also predicted that total uncompensated care would grow to \$27.6 billion by 1995, including \$11.0 billion for uncompensated physician care.

In this pro forma, it is also possible to quantify the costs to facilities for ED services provided to the remaining 83.8% of uninsured patients discharged home following emergency medical screening and stabilization. Past ACEP President Dr. Robert Williams' analysis of direct and indirect costs represent a benchmark in this regard.²⁸ For all visits, this prospective study of ED services in six Michigan hospitals resulted in an average cost of \$145.50. For the 13.7 million uninsured patients treated in EDs and not admitted to the hospital; total costs can therefore be estimated at slightly less than \$2 billion in 1996.

Although it is difficult to quantify the fully loaded costs of physician services rendered to uninsured patients

Table 7.

Outpatient ED Facility Costs

Estimated ED Visits by Uninsured.....	16,388,736
Admission Ratio Through ED.....	0.162
ED Discharge Ratio from ED.....	0.838
Total ED Outpatient Visits.....	13,733,76
Estimated Hospital Costs per Visit	\$145.50
Estimated Uninsured Hospital Outpatient ED Costs.....	\$1,998,262,191.74
Estimated Payment Ratio Uninsured.....	0.30
Estimated Uninsured Payments.....	\$599,478,657.52
Estimated Uncompensated Hospital Outpatient Costs.....	\$1,398,783,534.22

admitted through the ED, the components of care are not. The 2.6 million admissions could reasonably be expected to result in at least 10 million bed days. Admitting physicians could be expected to see their patients at least once each day during their four-to-five-day hospital stay. At least one major consultation could be expected to be required during the vast majority of these admissions, with subsequent periodic follow-up by the consulting physician. Hospital-based radiologists, pathologists, and cardiologists providing interpretive services could anticipate several minor consultations. A predictable fraction of patients admitted through the ED will require at least one major surgical intervention. If so, the services of surgical assistants and anesthesiologists would be required. Taken altogether, it would not be unreasonable to assume that the direct contributions of other physicians over the length of stay of uninsured patients admitted through the ED might be threefold the direct emergency physician costs; \$1.8 to \$1.9 billion would represent less than 20% of the total costs of uncompensated care estimated by the CBO for 1995.

Because physician practices are not required to make the same annual reports HCFA and many state governments require of hospitals, it is even more difficult to quantify the costs of physician services to uninsured ED patients arising from back-up panel services. Yet it is a virtual certainty that consultation is sought for a far larger percentage of ED patients than those who are ultimately admitted to the hospital. The subsequent costs to back-up panel specialists involved in the treatment, for example, of a long bone fracture requiring four to six weeks of healing, splinting and recasting, remain to be fully considered. It is not unreasonable to assume, however, that the full professional costs of outpatient care for the 83.8% of uninsured ED patients not requiring hospitalization might approach those of the remaining patients admitted to the hospital. If so, then EMTALA-related services may account for 40% to 50% of all uncompensated costs rendered in 1996.

Beyond the commitment of hospitals and physicians participating in the safety net, EMTALA has become the federal instrument that affords the uninsured the same hospital care benefits for life-threatening illnesses and injuries that would be expected if they were insured. This right was at the core of the recent Supreme Court decision in *Galen v. Rose*, which held that a hospital's obligation to patients admitted through the ED extends until they are stable for discharge home. Worse, as the Agency for Health Policy and Research analysis suggests, the costs of acute hospital care may be higher for the insured patient sector because of delays in continuing care resulting from lack of access to non-hospital services. The full costs of ED outpatient and hospital inpatient care rendered to the uninsured by their safety net providers in 1996 can be crudely estimated at between \$20 and \$25 billion. This estimate is worthy of validation by statistical methods,

given the importance of EMTALA in the continuing health care policy debates.

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Health Insurance Appendix: 1997

Selected Characteristics of Persons Without Health Insurance: 1997 (in Thousands)

	Total	Uninsured Number	%
	269,094	43,448	16.1
SEX AND AGE			
Male	131,705	23,130	17.6
Female	137,390	20,319	14.8
Under 18 years	71,682	10,743	15.0
18 to 24 years	25,201	7,582	30.1
25 to 34 years	39,354	9,162	23.3
35 to 44 years	44,462	7,699	17.3
45 to 64 years	56,313	7,928	14.1
65 years and over	32,082	333	1.0
RACIAL ORIGIN			
White	221,651	33,242	15.0
Non-Hispanic White	192,179	23,135	12.0
Black	34,598	7,432	21.5
Asian/ Pacific	10,492	2,172	20.7
Hispanic origin	30,773	10,534	34.2
EDUCATION (AGE 18+)			
No High School Diploma	35,244	9,189	26.1
HS Graduate	66,076	12,204	18.5
Some College	38,258	5,974	15.6
Associate Degree	13,996	1,726	12.3
Bachelor's Degree	43,837	3,611	8.2
Work Experience (Age 18 to 64)			
Worked During Year	135,568	24,572	18.1
Worked Full Time	111,174	18,698	16.8
Worked Part Time	24,394	5,874	24.1
Did Not Work	29,762	7,800	26.2
NATIONAL ORIGIN			
Native	242,813	34,444	14.2
Foreign-born	26,281	9,003	34.3
Naturalized citizen	9,739	1,798	18.5
Not a citizen	16,542	7,206	43.6

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The Safety Net and Current Federal Health Care Policy

FEDERAL GOVERNMENT AFFAIRS COMMITTEE REPORT

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BACKGROUND

The health care system of the United States is a great paradox. On one hand, technological advances and biological research have created a capacity to treat disease that is virtually unparalleled. The system has produced many of the world's advances in pharmaceuticals and high-tech treatments for a wide range of medical conditions. Despite these advances, the delivery of health care remains fragmented and inefficient. Over 43 million US residents currently do not have health insurance,¹ and over 50 million Americans spend at least one month without health insurance each year.^{2,3} The emergency department has become the routine and sometimes only source of care for many of the uninsured.⁴⁻⁶ The reliability and accessibility of the ED have enabled it to serve as a critical safety net for the fragmented US health care system.

The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates stabilizing care for any individual who presents to an ED regardless of ability to pay for services.⁷ Initially authorized in 1986, EMTALA has become the statutory guarantee for safety net care. The statute specifically outlines requirements for a medical screening examination, stabilizing care, and appropriate transfer of patients following stabilization. Although this statute guarantees care for patients, there is no mandate or provision for reimbursing providers of safety net care. An important goal for the American College of Emergency Physicians and its Federal Government Affairs Committee (FGAC) is to clearly outline the obligations of emergency physicians and hospitals under EMTALA. Whether conflict arises between payer groups and providers, among

competing providers, or between providers and the government, the EMTALA statute lies at the center of any debate over the organization and delivery of safety net care.

OVERVIEW

The FGAC is actively involved with issues that impact the viability of the health care safety net. Its primary safety net activities include new regulations for EMTALA and active pursuit of prudent layperson legislation. Other areas of consideration include negotiated rulemaking for an ambulance fee schedule and revision of practice expense regulations.

EMTALA REGULATIONS

In a move to protect managed care plan enrollees who were being denied access and/or coverage of emergency services, the Health Care Finance Administration (HCFA) issued a proposed special advisory bulletin on the EMTALA statute in December 1998. The bulletin covered issues such as dual staffing arrangements and practices that promote compliance with EMTALA. Specifically, compliance practices include the elimination of prior authorization requirements, appropriate completion of financial responsibility forms in relation to the medical screening examination, qualifications for medical personnel who perform the medical screening examination, and procedures for handling patient inquiries about financial liability and voluntary patient departures from the ED without receiving care. The Clinton administration has been very clear about its intent to enforce the EMTALA statute.⁸ Violations of the statute can result in civil penalties of up to \$50,000 per

offense and exclusion of physicians and/or hospitals from participation in all federal health care programs. In an ongoing effort to educate providers and managed care plans about the requirements of EMTALA, ACEP participated in an EMTALA Working Group that led to many of the positive recommendations in HCFA's proposed special advisory bulletin. Because of several outstanding issues that remain controversial, ACEP has encouraged HCFA and the Office of the Inspector General to reconvene the Working Group on the EMTALA statute for further discussions. The FGAC has followed the regulatory process of EMTALA very closely, and this statute continues to be a high priority.

PRUDENT LAYPERSON LEGISLATION

The prudent layperson standard for coverage of emergency medical care has been the top legislative priority of the FGAC for the past several years. Because the prudent layperson standard applies to patients with insurance, it may appear initially that the standard does not relate directly to the safety net role of EDs; however, the standard does more than simply define an emergency medical condition. It also addresses issues such as prior authorization and denials of coverage for emergency care. In this respect, the prudent layperson standard helps ensure that the ED can effectively carry out its role of providing emergency care for all patients. Also, the language of the statute discourages health plans from developing lists of "appropriate" emergency medical conditions. It is significant that the prudent layperson standard defends the rights of patients to have access to the ED when symptoms develop that *they* believe need emergent medical care. Attempts to limit access through prior authorization and retrospective denials for "inappropriate" ED visits are eliminated when the prudent layperson standard is met. The prudent layperson standard breaks down barriers for insured patients as they seek appropriate emergency care. In doing so, it reflects many of the principles embodied in the EMTALA statute. Patients who believe they are having an emergency belong in the ED, not struggling with their health plan to authorize ED care.

The prudent layperson standard was approved for Medicare and Medicaid patients in the Balanced Budget Act of 1997. In the 105th Congress, the prudent layperson standard achieved broad bipartisan support in the "Access to Emergency Medical Services Act," introduced by Congressman Ben Cardin of Maryland. Unfortunately, debates over other aspects of managed care reform prevented the prudent layperson standard from being adopted. The 106th Congress has convened, and the prudent layperson standard has been included in many of the patient protection bills already introduced. The Cardin legislation has been reintroduced, and the FGAC is hopeful that it will be adopted in this Congress, either by itself or as part of a more comprehensive patient protection bill.

NEGOTIATED RULEMAKING FOR AMBULANCE FEE SCHEDULE

The Balanced Budget Act instructed HCFA to develop an ambulance fee schedule for the Medicare program. The proposed rule for this fee schedule was published in June 1997. It would link Medicare payment for ambulance services to whether advanced life support or basic life support care was provided. HCFA estimates that \$65 million will be saved in calendar year 2000 with its proposed rule; however, the agency received many comments about potential adverse effects of the proposal and therefore will convene a negotiated rulemaking committee to address the ambulance fee schedule. Dr. Robert Bass is representing ACEP and the National Association of Emergency Medical Services Physicians on this committee. This issue is important for the safety net, because a viable and efficient emergency medical services system is critical for the health care system. There are significant concerns that the proposal will jeopardize the ability of many EMS systems to continue to deliver prompt and efficient emergency medical care. The FGAC is following the ambulance fee schedule issue very closely.

UNCOMPENSATED CARE AND RESOURCE-BASED RELATIVE VALUE SCALE

For the past several months, ACEP has been actively addressing proposed changes by HCFA to the formulae used to determine "practice expense" relative value units. The proposed changes by HCFA have used data provided by the American Medical Association's socioeconomic monitoring system survey. These data depict emergency physicians as having very low levels of practice expense due to hospital-based practice settings. The impact of applying these data was a significant reduction in the total relative value units allocated for emergency medicine. ACEP commissioned its own study (Lewin study), that has provided financial data demonstrating the impact uncompensated care has on the cost of our practices. This cost is in fact mandated by requirements of federal law, namely EMTALA.

The data from the Lewin study provided convincing evidence to officials at HCFA that a case can and should be made regarding the appropriate role of uncompensated care in determining relative value units for practice expense in our specialty. Although HCFA has accepted the validity of our argument, the full application of uncompensated care costs to our practice expense relative value units has not been implemented. Rather, HCFA has agreed to utilize "all physician averages" to calculate certain categories of physician expense. This compromise has resulted in a smaller decrease of the anticipated relative value units' reductions. The College is actively pursuing this issue with HCFA through all appropriate means.

The reductions in the resource-based relative value scale system will lower emergency physician reimbursements from Medicare, and all payers that base fee schedules on these formulae. Therefore, aggressively addressing the impact of uncompensated care in future determinations of the resource-based relative value scale system should remain a high priority for the College. The opportunity now exists to take this even further so that the inherent problems associated with uncompensated care in emergency medicine can be addressed. By adjusting the resource-based relative value scale to offset the negative financial impact created by uncompensated care, a new mechanism of cost pass through can be established to cover and pay for health care to the uninsured.

Cost containment implemented by managed care has resulted in the elimination of traditional mechanisms of "cost pass through." This is a crisis to emergency medicine and our patients. In lieu of other direct measures to provide coverage for the uninsured, a mechanism that addresses the cost of uncompensated care through the resource-based relative value scale may be our interim solution and long-term salvation.

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The Emergency Department As A Public Safety Net

Public Health Committee

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FACTORS LIMITING ACCESS TO PRIMARY HEALTH CARE

The United States is one of the only industrial countries without a comprehensive system for financing or delivering acute medical care. Despite the absence of such a system, in 1994, 47% of medical care costs were born by the government through Medicare, Medicaid, military and Veterans Administration programs, the Indian Health Service, and government employment. Of the remaining health care costs, 21% were paid by private industry through employer-paid insurance, 26% were paid directly by consumers, and 6% of costs were contributed by the medical care industry and others in the form of charity care and bad debt.¹

There are many barriers to accessing health care, the most obvious of which is the lack of health insurance. During all of 1997, 43.4 million US residents were uninsured, but single point-in-time estimates of uninsured status would be higher.² An additional 29 million citizens are underinsured and lack sufficient coverage for essential health care. This means that 31% of US residents under the age of 65 are without adequate health care coverage.³ The number of uninsured US residents increases by over one million annually.

There are other financial barriers that limit even insured citizens' access to health care. These include spending caps, waiting periods, restricted coverage for specific medical conditions, long appointment waiting times for Medicaid or health maintenance organization insurance categories, disagreements about medical necessity, or outright refusal of insurance payment. In addition to financial barriers to care,

certain individuals or groups may face such complex non-financial barriers to care as geographic unavailability of services, transportation issues, restricted appointment times, inadequate access provisions for the disabled, lack of appropriate translation services, and lack of culturally appropriate providers.

Faced with these barriers to medical care, people frequently turn to a loosely defined "medical care safety net," consisting primarily of community health centers, categorical or non-categorical clinics operated by local or state departments of public health, privately operated charitable clinics, and the nation's 4,000 emergency departments. In contrast to other safety net providers, EDs define their mission in terms of unlimited access regardless of citizenship, insurance status, ability to pay, day of week, or time of day. Moreover, EDs are the only safety net providers allowing access to both outpatient and inpatient services, covering the full range of medical specialties and providing access to the laboratory, radiological, and support services characterizing the hospital environment. In many cases the EDs may be the only source of pharmaceuticals during off-hours or for patients without financial resources.

The ED is the only source of care available for certain populations. The 1996 welfare reform legislation severed the link between Medicaid and Aid to Families with Dependent Children, legal immigrant status, and disability due to substance abuse. This has had a significant impact on health care for the poor and immigrant populations. Decreasing access for these groups to traditional health care services will lead to a further primary care burden for EDs since EDs were exempted from these restrictions.

EDs are the only element of the health care safety net whose function has been defined by federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), which mandates that all EDs provide screening, stabilization, and/or appropriate transfer to all patients with any medical condition. EDs are the most integrated element of the safety net. They are the providers of last resort and in many cases the access point of choice for competent, comprehensive, and efficient medical care. Despite the misconception that patient use of the ED represents a failure of primary care and is contrary to the public health focus on preventive services, EDs are a mainstay of the medical care safety net in the US.

THE ROLE OF EMERGENCY MEDICINE IN PUBLIC HEALTH

There are almost 100 million patient visits to more than 4,000 EDs annually in the US. This creates a unique opportunity to reach populations with limited access to health care and to monitor disease patterns and identify emerging diseases. The nation's ED safety net provides essential health care for both acute and chronic diseases and even preventive services such as vaccinations (influenza) and prophylaxis for sexually transmitted disease contacts. EDs are also a common source of care for infectious diseases such as foodborne infections, influenza, sexually transmitted disease, hepatitis, and community-acquired pneumonia. The surveillance of these visits can provide important data to describe infectious disease patterns and identify outbreaks. The ED is also the primary source of care for injuries in our country. Despite this wealth of information, the ED network remains a largely untapped data bank for public health surveillance and policy analysis.

The EMTALA-mandated ED medical screening exams also can be used to screen for public health problems such as undiagnosed hypertension, diabetes, sexually transmitted disease, and domestic violence, allowing for early intervention and treatment. Although the ED has been termed "the provider of last resort" for health care, it is often the only resort. The ED is unique in its care for rape victims, rabies prophylaxis, trauma stabilization, and toxicology. The ED and emergency medical services are also the ultimate source of disaster preparation and response, including recent anti-terrorism initiatives.

HEALTHY PEOPLE 2010

Assuring access to crucial health services is seen as a public health responsibility in our society, but it is a responsibility that local, state, and federal agencies are not expected to fulfill single-handedly. In carrying out this responsibility, public sector agencies encourage and require private sector action or provide certain services directly. Such actions are predicated on a community consensus

about the value of access to health services, and reflect a measurable public commitment to each member of society. In practical terms, this includes regulation of health services in both the public and private sectors and the maintenance of accountability to the public by setting objectives and reporting on progress. This involves supporting crucial services that have worked well for so long that they are now taken for granted, and developing adequate responses in the event of crisis situations. As needs arise, it also includes seeing to the implementation of new legislative mandates and assuring compliance with existing statutory responsibilities.⁴

The broad scope of coverage and around-the-clock availability of ED services allows public health agencies to meet community expectations that critical health services will be available. EDs alone are expected to at least stabilize the most severely ill and injured and to provide ambulatory care for vast numbers of patients who face financial, attitudinal, and other barriers to receiving care elsewhere. As EDs carry out these responsibilities, they are strategically well positioned to monitor gaps in the health care safety net and meet immediate health care needs. Both roles, direct service and safety net monitoring, are integral parts of the safety net function and should be viewed as public health activities deserving of community support. Much remains to be accomplished in the service and monitoring roles. Although ED services are widely available in the US, they vary widely in accessibility and quality.⁵ In addition, the capacity of EDs to monitor health care access is largely undeveloped, as are methods of reporting and applying this information.

Each decade the federal government creates a series of goals and objectives for health care for the US called "Healthy People." These goals and objectives focus the actions of agencies and individuals responsible for implementing public health strategies at the local, state, and national levels. They result in national action and funding to meet the goals. In this context, setting goals and objectives for improved access to ED services is important for emergency medicine to shore up the health care safety net and fulfill the public health assurance function. The "Healthy People 2010" report is scheduled to be published by the US Department of Health and Human Services in the year 2000, and will include a section devoted to improving access to emergency services. The 2010 report will be the first in the "Healthy People" series to include emergency services. The draft report, published in the fall of 1998, included a set of six emergency service objectives that seek to:

- Assure timely prehospital EMS responses.
- Protect health plan enrollees from coverage and payment policies that impede access to emergency services.

- Establish a single toll-free number for access to poison control centers.
- Assure access to timely care for acute myocardial infarction and out-of-hospital cardiac arrest.
- Assure access to emergency care that meets the special needs of children.
- Assure access to follow-up care for patients with mental health problems treated in EDs.

These objectives will ensure that emergency services will be a part of the nation's focus for health care for the first decade of the new millennium.

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The Safety Net and Emergency Medical Services

EMS COMMITTEE

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The out-of-hospital care US residents know and depend on today did not exist prior to 1966. In that year the National Academy of Sciences/National Research Council published its landmark report, "Accidental Death and Disability: The Neglected Disease of Modern Society." This publication dramatically pointed out our nation's deficiencies in emergency medical care, both in the field and the emergency department settings. It led to a mandate by physicians and the general public to improve our nation's out-of-hospital and in-hospital emergency medical care.

Over the past 30 years we have seen enormous advances in emergency medical care, education, and research. The creation of the National Highway Transportation Safety Administration, the establishment of a national emergency medical services curriculum, the establishment of an EMS agency for children, the development of the automatic defibrillator, and the creation of "EMS: Agenda for the Future" are just a few of the advances that out-of-hospital care providers have made. As a nation, we expect that if we have a heart attack at home we will have expedient access to well-trained health care professionals who will provide us with life-saving medical interventions. Our current health care environment, however, has the potential to stifle, even reverse, the advances made since 1966.

The goal of out-of-hospital medical care is to provide the highest quality and most efficient patient-oriented treatment possible. EMS provide medical assessment and transport to anyone who requires it, and episodic emergency medical care to the acutely injured or sick without regard to insurance status. Emergency physicians provide medical

oversight for this vital service. Emergency physicians make on-line medical decisions, provide medical protocols, monitor the quality of care provided by EMS personnel, provide educational programs for EMS providers and help write local, state, and federal policies for EMS.

The ability of EMS personnel and emergency physicians to provide emergency medical care is being eroded in our present health care environment. The EMS safety net is being stressed by the growing demands associated with our aging population and the inability of the health care system to manage both insured and uninsured patients.

Managed care organizations are no longer willing to pay for EMS preparedness. The Health Care Finance Administration has been mandated to "ensure Medicare pays only for needed ambulance services." The public depends on being able to call 911 and receive high-quality health care in an expedient manner. As health care providers, emergency physicians must insist on quality medical care that is accessible to everyone. They must not allow vital medical care, such as EMS, to be cut in order to meet the bottom line.

Emergency departments are closing because of the financial strain caused by the Health Care Finance Administration and managed care's mandate to save money. These closures are further straining EMS, especially in rural areas where ambulances must travel greater distances to hospitals, thus delaying medical care and increasing EMS turnaround time. In addition, hospital closures have decreased the amount of local physician EMS oversight in rural communities.

Managed care may create a two-tiered system of out-of-hospital care. One large managed care organization could merge with an ambulance service and provide EMS for their patients only. This merger could result in people in the same community receiving different EMS response times and being treated differently based solely on their health care plans. Unanswered questions arise: Who will provide medical oversight, the local EMS medical director, the national ambulance company or the health maintenance organization? What happens if the health maintenance organization contracts with a national transporting agency that does not have an operation in the local area? Will ambulances refuse to transport someone who could not provide the correct health maintenance organization card?

EMS personnel and emergency physicians are the only providers of health care to many of the poor and uninsured. Unfortunately, this includes a large number of the very young and the elderly. Who is responsible for ensuring that these persons have access to out-of-hospital medical care? The government has established very strict criteria for ensuring that everyone who presents to a hospital property seeking care is evaluated and treated. But without a well-prepared EMS system, many of these patients may never make it to the hospital. Time is critical in many situations. For example, a patient in cardiopulmonary arrest must receive medical intervention

within four minutes of onset or suffer irreparable, if not fatal, consequences.

We must create a federal government agency whose mandate is to ensure that high-quality, cost-effective medical care is provided to everyone. The EMS system and EDs must be supported as a public health necessity. Patients with acute medical conditions, as determined solely by the patient and/or caregiver, must be able to depend on the EMS system to respond to their needs in a timely manner. EMS personnel must be able to bring patients to the closest hospital with the necessary emergency physicians and on-call physicians to provide appropriate medical care.

In summary, this country needs national standards for out-of-hospital medical care that can be adapted to local community needs. There must also be a federal government agency with a mandate to ensure that sufficient resources and funding are available to provide appropriate out-of-hospital and ED care to all that need it. More than 43 million US residents have no health insurance. As emergency physicians, we cannot allow anyone to be denied access to emergency medical care based on insurance status. Emergency medical care is not a privilege based on an individual's ability to live in a community providing this service, or based on their financial status. Rather, it is a right. It is the safety net that all depend on, 24 hours a day, seven days a week.

Emergency Department Back-up Panels: A Critical Component Of The Safety Net Problem

Emergency Medicine Practice Committee

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INTRODUCTION

Emergency department back-up panels are in a very fragile state. In light of a robust national economy, this situation is ironic for a variety of reasons.

Ten years ago, the US was in the midst of an economic downturn. The total of uninsured people swelled as increasing numbers had no form of health insurance through employer-based coverage. Government health care programs covered some of these individuals, but the reimbursement rates were meager. The overall payer mix of patients presenting to emergency departments was poor. In many areas of the country, over 50% of patients were either completely uninsured or were covered by various government health programs that paid poorly. Many physicians at that time either resigned from ED call panel participation or threatened to do so. Crises ensued around the nation with varying local solutions.

In 1999 the national economy is robust with unemployment rates the lowest in decades in most areas of the country. One would presume that more individuals are eligible for some form of health care coverage than ever before. The reported percentage of insured persons under the age of 65 has risen nationally from 13% in 1987 to nearly 18% today. It is noteworthy that today 85% of all employer-sponsored health care programs are in managed care plans. Under the rules of managed care, essentially all services for members of managed care organizations (MCOs) must be provided by contracted plan providers. Fee-for-service insurance is quickly becoming an exception, if not an anomaly. For these reasons and others, ED call panels in many areas of the country are once again under siege.

Why are ED call panels under siege at a time when the American economy is doing better than ever before? The current ED back-up call panel crisis in California prompted the formation of a task force with representatives of the state's ACEP chapter, the California Medical Association, and the California Health Care Association, the trade organization for the state's hospitals. The results of the task force survey are included in tables 1-4, and support earlier speculation that ED back-up panels have been undermined by the concurrent growth in both managed care and the number of ED patients without health insurance.¹

HOW DO ED CALL PANELS FUNCTION?

Historically, emergency department call panels were composed of volunteer physicians from the medical staff, most of whom were in the process of trying to build traditional fee-for-service medical practices. Emergency department call panel participation was considered an excellent way to capture "unattached" patients who had no regular physician. Access to ED call panels was often very competitive.

Table 1.
How Serious a Problem Are ED Back-up Panels In Your Hospital?

	ED Medical Directors %	Medical Staff Chiefs %	Hospital Executives %	Combined Average %
Very serious	8.....	24	21	18
Somewhat serious	41	39	47	42
Not serious	51	37	32	40

Today, there are very few unattached paying patients; most paying patients coming to the ED already have a private physician or are members of a MCO that requires repatriation of stabilized patients to plan physicians and/or hospitals. Most unattached ED patients are either uninsured or are covered by poor-paying government programs.

WHY HAVE ED BACK-UP PANELS COME UNDER SIEGE AGAIN?

Problems from the 80s still pertain to call panels of the 90s. Large numbers of Americans remain unemployed. Many of these individuals and their families remain reliant on government-sponsored programs for health care coverage. Medicaid in most states pays a fraction of what Medicare or commercial payers do. County programs, as the provider of last resort, generally reimburse even less than Medicaid. Many individuals do not qualify for any sort of government coverage and truly are "private payers," which in most cases may be considered "non-payers."

Clearly, though, the main contemporary confounding factor affecting the stability of ED back-up call panels is managed care. Very few managed care group physicians participate on ED back-up call panels. Simply stated, they "take care of their own," but nothing more. Managed care has been successful in moving a large percentage of patients with some type of health care coverage from fee-for-service to managed care settings. This leaves few paying patients for traditional fee-for-service physicians, especially those participating on ED back-up call panels.

When managed care patients come to an ED, they are referred to specialists who are under contract or directly employed by their MCO, and do not have the option of being referred to the back-up call panel physician. As a result, private physicians who continue to serve on ED back-up call panels are left with only the uninsured and those with poor-paying government programs. Private physicians have tired of this, and are quitting or demanding

Table 2.
If Your Facility Is Having Problems with ED Back-up Panels, Which Medical Specialties Are the Most Difficult to Cover (In Order of Most Frequently Reported)?

- 1 Neurosurgery
- 2 Thoracic Surgery
- 3 Vascular Surgery
- 4 Head and Neck Surgery
- 5 Oral Surgery
- 6 Neurology
- 7 Psychiatry
- 8 Hand Surgery
- 9 Ophthalmology
- 10 Orthopedic Surgery

guaranteed reimbursement from hospitals.

Obviously, there are other factors and nuances that affect ED back-up call panel crises. In certain specialties, such as neurosurgery, there simply may not be enough potential call panel participants to cover a schedule. Regional coverage strategies may have some impact in these situations, but this is a different consideration that demands analysis.

In summary, more US residents are covered by health insurance plans today than in recent decades, the vast majority through managed care plans. Numbers of uninsured nonetheless remain high. MCOs in large part have not participated in providing charity care to the uninsured and the underinsured, as recent published reports have confirmed.² Private physicians who are unaffiliated with managed care plans are quickly becoming weary of shouldering the burden of uncompensated or undercompensated care. ED back-up call panels are in jeopardy once again.

Table 3.
Rank the Reasons for Your Hospital's Back-up Problem (In Order of Importance)

1. Physicians do not equate hospital privileges with a duty to assist their hospital in fulfilling its public service responsibilities. *
2. Lack of adequate payment or no payment for such services under managed care.
3. Physicians resent not being paid for ED call when they compare their incomes with the profits and salaries of corporate executives.
4. Physicians at our hospital are no longer willing to serve in the ED as a way of building their practice; with managed care penetration at current levels, such service is not as relevant to practice growth.
5. Our medical staff provides ED on-call services on a voluntary basis, and we do not have sufficient volunteers.
6. We have a mandatory medical staff requirement to serve ED back-up call, but we have difficulty enforcing this requirement.
7. Many of our physicians are limiting their medical staff affiliations, thereby reducing the number available in our hospital to take call in a particular specialty; this is exacerbated by medical group/hospital consolidation.
8. Managed care contracting specialists are frequently not available for ED consultations because it is not part of their contractual arrangement.
9. Managed care has had a negative impact on specialty availability in our ED because so many specialists have been terminated from MCO panels.
10. The aging of our medical staff, eg, ED call, is difficult for older physicians.

* This item ranked #1 in CAL/ACEP survey, #3 in the California Health Care Association survey, and #4 in the California Medical Association survey.

EMTALA AND ED BACK-UP PANELS

EMTALA mandates that medical screening exams and necessary stabilization be provided to all patients who seek care in EDs. Hospitals are specified in the federal law as the entities responsible for meeting this mandate. Penalties for failure to do so are severe. Physicians as a class, however, are not similarly obligated under federal law as they are not obligated to participate on ED call panels. Those who choose to participate must adhere to strict regulations. The result is that hospitals that choose to maintain EDs essentially are responsible for staffing the ED back-up call panels one way or another. Physicians tend to have the opinion that "if the hospital wants to have an ED, it's up to the hospital to do it," including making any and all arrangements necessary to maintain an ED back-up call roster.

FUNDING ED BACK-UP PANELS

Many medical staffs have looked to hospitals to reimburse those physicians who participate on ED back-up call panels and who are exposed to large amounts of uncompensated care. This strategy has worked in some situations, in that ongoing ED back-up call panels have been maintained, but at a significant cost to hospitals. Hospitals report that they simply do not have the resources to maintain ED back-up call panels. This may well be true, even though they tend to have larger resource bases from which to absorb such uncompensated costs.

Hospitals have used several strategies for maintaining ED back-up panels. Participation in ED coverage can be mandated as a provision of medical staff membership. Mandates in facilities with disproportionate exposure to the uninsured, however, only accelerate the deterioration of their medical staffs and ED back-up panels. Hospitals can enter into exclusive agreements with physicians for specialties that are difficult to cover. Hospitals can sponsor call panel medical groups that resemble traditional

combined billing arrangements with emergency medical groups. In exchange for guaranteeing rates of reimbursement pegged to local market requirements, typically on a par with Medicare rates, ED back-up physicians allow hospitals or third parties, such as the ED medical director, to act as their billing agent for all services provided in the ED. In most cases, this requires augmentation of actual collections by the hospital. Transfer agreements for services that are unavailable onsite are often necessary as well, particularly in rural facilities.

As suggested above, MCOs operate at arms length from the EMTALA mandate and have largely avoided direct participation on ED back-up call panels. In market terms, they do not view themselves as being "at risk" for the medical care of the uninsured. It would seem logical that they might be concerned if their business practices threatened timely access to emergency medical services for their own populations. That is increasingly the case today. Along with hospitals and medical staffs, MCOs must bear their fair share of the burden of providing care to those unfortunate individuals who do not have health care coverage. Strategies to address this extremely serious problem should be explored.

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Table 4.
*How Does Your Medical Staff Currently Provide Back-up ED Coverage?**

Voluntary ED coverage.....	24%
Mandatory ED coverage as a condition of medical staff membership	52%
Contracting for on-call services.....	38%
Insurance coverage for on-call physicians.....	11%
Daily stipends.....	22%

* Aggregate exceeds 100% due to more than one arrangement in individual hospitals.

Teaching Hospitals And The Medically Indigent

ACADEMIC AFFAIRS COMMITTEE

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THE MEDICALLY INDIGENT AND GRADUATE MEDICAL EDUCATION

Of the 6,200 hospitals in the US, approximately 400 are members of the Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges (AAMC). About 320 of these are short-term, non-federal general acute care hospitals (249 private and 70 public). Of these, 280 are affiliated with a medical school, and therefore defined as major teaching hospitals. A COTH survey¹ has recently shown that 30% of patients admitted to teaching hospitals are medically indigent (defined as uninsured or Medicaid only). The corresponding figure for public teaching hospitals is 60%.

Of the 121 emergency medicine residency programs in 1998, 91 are in major teaching hospitals, and 35 are in public teaching hospitals.² For all hospitals with emergency medicine residency programs, 33.5% of patients admitted were medically indigent (median, 26.9%). For the 35 public teaching hospitals, the figure was 52% (median, 51%).³ Although data on the insurance status of ED patients are not available, requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) would imply that the proportion of medically indigent patients seen in the ED is even larger.

Analyzing the primary clinical sites of the 20 emergency medical residency programs established since 1994 (see below), only 20% of patients admitted are medically indigent (median, 17.1%). It is possible that a differential impact on public teaching hospitals from decreases in graduate medical education (GME) funding and other health care expenditures might be the cause. However,

further analysis must be done before such a conclusion can be drawn.

IMPACT OF FUNDING CHANGES ON EM RESIDENCY TRAINING

Number of Years of Postgraduate Training

The 1995 Medicare Preservation Act, implemented on October 1, 1996, limited direct medical education payments for the first time to the number of years required for board certification in a specialty. Emergency medicine is unique among the specialties in that both three- and four-year residency programs are accredited. For emergency medicine residents who started in 1996-97 in PGY 2-4 programs, the current year (1998-1999) is funded only at 50%; similarly, for emergency medicine residents who started the same year in PGY 1-4 programs, their final year (1999-2000) will be funded only at 50%.

Any previous postgraduate training before entering an emergency medicine program would of course decrease the number of years funded at 100%. Detailed information on the number of emergency medicine residents with previous postgraduate training is not available. However, in the 1999 "Emergency Medicine Residency Catalog," published by the Society for Academic Emergency Medicine, 107 of the 116 civilian emergency medicine residency programs state that they will consider applicants with prior postgraduate training. Another six will consider applicants with no more than one year of prior training.⁴

Current data suggest that these funding restrictions have not yet had a significant impact on the format of emergency medicine residency programs. Between 1994 and 1998, five

programs changed format; three with a one-year decrease and two with a one-year increase in postgraduate training. Of the 20 programs established since 1994, 15 are PGY 1-3, four are PGY 1-4, and one is PGY 2-4. Since the mid 1970s there has been a trend toward fewer PGY2-4 emergency medicine residency programs, but the proportion of PGY1-4 programs has remained stable.

In 1999, the American College of Emergency Physicians' Academic Affairs Committee, and the Council of Residency Directors in Emergency Medicine, have surveyed emergency medicine residency directors regarding their expectations of changes, including those in program format.

Cuts In GME Payments

The Balanced Budget Act of 1997 decreased graduate medical education (GME) payments in several ways:

- Capping the number of residents: Starting in FY 1998, a hospital's number of full-time equivalent residents could not exceed the number reported on or before 12/31/96. (At the request of the Society for Academic Emergency Medicine and other specialty organizations, a limited exemption was granted for institutions that established new residency programs between 1/1/95 and 8/5/97).
- Direct GME payments are capped also. To increase flexibility and allow the merger of teaching hospitals, the cap may be applied on an aggregate basis within an affiliated group.
- Indirect medical education payments, which were based on the resident bed ratio, and which then amounted to 7.7% for every 10% increment in that ratio, were to be decreased progressively to 7.0% in 1998, 6.5% in 1999, 6.0% in 2000, and 5.5% in 2001. In addition, the resident bed ratio also was capped at the 12/31/96 level to prevent hospitals from receiving increased indirect medical education payments through decreases in hospital bed count.

The issue of variability of Medicare GME payments to individual hospitals has been discussed frequently in various forums but has not yet been addressed by

Congress. "In 1995, 10% of teaching hospitals had per-resident payments of more than \$98,000, whereas the average payment for another 10% was below \$37,400. The national mean was \$62,700."⁵

Number of Residency Positions

A number of nationally known teaching hospitals made significant cuts in their resident complement in the early 1990s in response to expected decreases in GME funding. The Balanced Budget Act of 1997 anticipated the development of an incentive program to decrease resident complement, although this has not yet been implemented. Indeed, a previously established pilot program in New York has seen the defection of 15 out of 49 hospitals since 1997, reportedly because of the cost of replacement staff.⁶

Much of the increase in the number of residents in US training programs in the 80s and early 90s was in subspecialty areas. Generalist programs, such as general internal medicine, saw significant decreases in resident numbers; general internal medicine did not catch up to its 1989 level until 1995. Family medicine, on a plateau between 1987 and 1993, has seen impressive annual increases since then. However, emergency medicine is the specialty that has grown consistently and significantly since 1987. (See accompanying table and figure.)⁷⁻¹⁶

Although published resident numbers vary because of counting techniques, there were approximately 35% more residents in civilian emergency medicine programs in 1998 than in 1994, an increase of about 870.^{3,4} Most of this increase came from new residency programs, but part of the increase was due to a net increase in resident complement in existing programs. The specific numbers are as follows:

- 20 new emergency medicine programs added 543 additional residents
- 10 programs not yet at full complement in 1994 had 129 additional residents
- 40 programs that increased their complement had 259 additional residents

Table 1.
Number of Residents by Specialty

	Number of residents on duty September 1, by specialty										
	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Internal Medicine (M)	18153	18074	16854	18734	18662	19191	20603	20693	21071	21298	21714
IM, Subspecialties	5637	5841	3200	5904	6878	7403	8277	8019	7742	7432	7373
IM, General	12516	12233	13654	12830	11784	11788	12326	12674	13329	13866	14341
Yearly Increase (%)		-2.26	11.62	-6.03	-8.15	0.03	4.56	2.82	5.17	4.03	3.43
Family Medicine	7346	7175	6332	6680	6610	6976	7976	8587	9261	10049	10501
Yearly Increase (%)		-2.33	-11.75	5.50	-1.05	5.54	14.33	7.66	7.85	8.51	4.50
Emergency Medicine	1301	1311	1380	1781	1867	2115	2434	2609	2812	3034	3239
Yearly Increase (%)		0.77	5.26	29.06	4.83	13.28	15.08	7.19	7.78	7.89	6.76

- Nine programs that decreased their complement had 62 fewer residents

Several emergency medicine residency program "downsizing" surveys were conducted between 1995 and 1997 to evaluate the effect of anticipated cutbacks in GME funding.¹⁷⁻¹⁹ The results indicated that 5% to 9% of programs were cutting positions, a figure that is consistent with the number of programs that have decreased their complement between 1994 and 1998. The overall change, however, was strongly positive, as is shown in table 1.

The ACEP Academic Affairs Committee and the Council of Residency Directors in Emergency Medicine are conducting follow-up surveys of emergency medicine residency directors regarding their expectations of changes in funding and resident complement. Results are expected in the spring-summer of 1999.

THE FUTURE OF GME

The proposal to move GME funding completely out of Medicare has been made on several occasions, most recently by the National Bipartisan Commission on the Future of Medicare. This was viewed with great concern in academic medicine, given the inherent instability of the

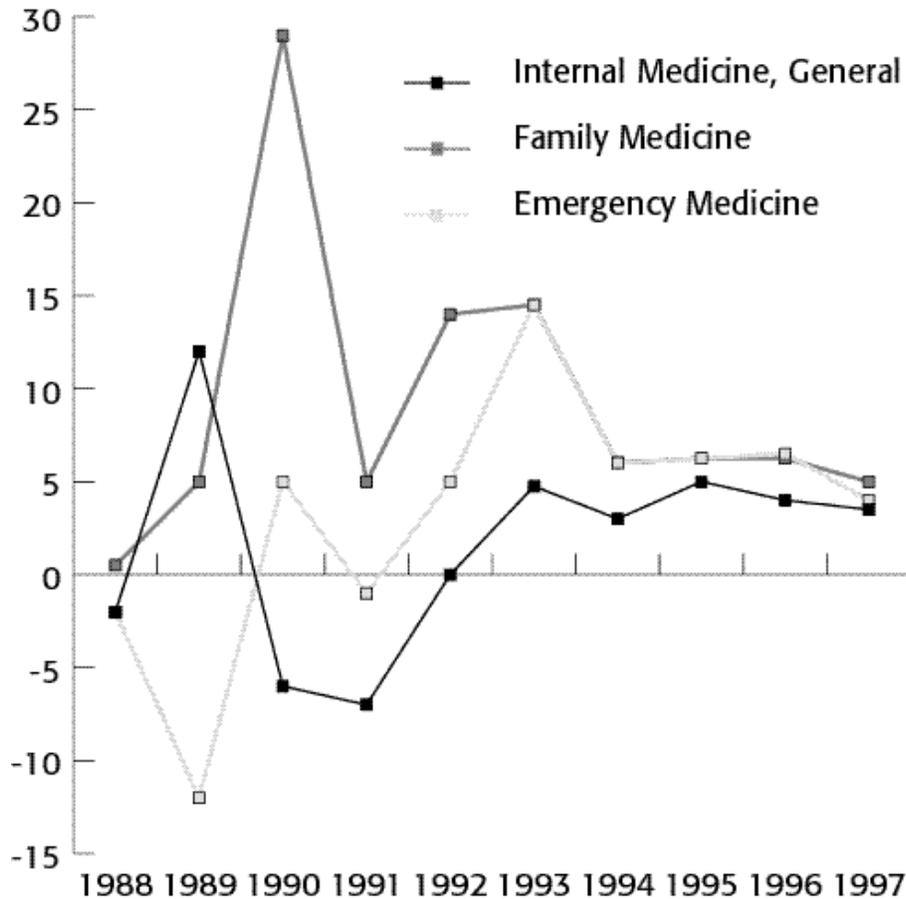
appropriations process. Because the Commission failed to achieve the majority necessary to issue a report on Medicare reforms and disbanded in March 1999, the immediate urgency of this issue has waned somewhat.

The issue of GME financing appears now to have been returned to its original venue, the Council on Graduate Medical Education. At its meeting in April 1999, the Council recommended the formation of yet another advisory panel.²⁰

ADDITIONAL FINANCIAL CONSTRAINTS ON TEACHING HOSPITALS

In July 1996, the Health Care Finance Administration (HCFA) imposed strict regulations on teaching physician documentation. In addition, teaching hospitals have been the object of targeted scrutiny by the Office of the Inspector General. A teaching physician who wishes to bill Medicare for a service that involves a resident must be present in the ED while the service is being performed and must personally examine the patient. This requirement places significant restrictions on a teaching physician's billing opportunities in an ED.

Figure 1 - Annual Increases/Decreases by Specialty



Hospital EDs and emergency physicians are currently facing further cuts in funding from new HCFA regulations, including physician practice expense relative value units and the proposed prospective payment system for hospital out-patient services. According to HCFA, the new practice expense payment system will result in a 2.5% reduction in Medicare reimbursement for emergency medicine in each of the four years of the proposed phase-in period. Earlier estimates from the Association of American Medical Colleges suggest that academic emergency medicine may face larger cuts, up to 14%.

During discussions with representatives from ACEP, HCFA recognized that uncompensated care is a significantly greater problem for emergency medicine than for other specialties, and stated that "these issues require further examination."

With many payers negotiating rates for all services, including those provided in an ED, hospitals can no longer shift the costs of ED screening and stabilizing medically indigent patients to other ED patient groups, the historical method of funding such care.

EMTALA requires that physician and other staffing in EDs must be maintained at a high level 24 hours a day to provide a consistent quality of care to all patients. The combination of across-the-board funding reductions and the requirements of EMTALA place a great strain on the ability of emergency physicians and EDs to care for patients. Academic medical centers, particularly public teaching hospitals, see and treat a disproportionate number of medically indigent patients. These hospitals face the additional burdens of compliance with teaching physician regulations and decreases in federal GME funding. These factors will severely compromise the ability of academic medical centers to fulfill their triple responsibility of patient care, teaching, and research.

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Practice Expense And Uncompensated Care

REIMBURSEMENT COMMITTEE REPORT

Mason A. Smith, MD, FACEP, Chair

David McKenzie, ACEP Reimbursement Manager

The American College of Emergency Physicians has been working through the Relative Value Units Update Committee (RUC) process to increase awareness of the very real cost of uncompensated care as a practice expense. ACEP commissioned the Lewin Group to analyze the extent of this problem when it became clear that the Socioeconomic Monitoring System survey from the AMA, used by the Health Care Finance Administration (HCFA) as the basis for the transition of the practice expense component of the resource-based relative value system (RBRVS), did not capture data on uncompensated care. HCFA's recent acceptance of the Lewin Group report on this issue was a major breakthrough for ACEP, marking the first time the federal government recognized that the Emergency Medical Treatment and Active Labor Act (EMTALA) mandate generates special problems for emergency physicians. HCFA's recognition that the Socioeconomic Monitoring System survey drastically underestimates the true cost of providing emergency physician services prompted the organization to substitute the all-physicians average for practice expense for emergency physician's evaluation and management codes in the RBRVS. HCFA's Director of Plans and Providers also announced that the second segment of the four-year practice expense transition will be used to request third-party proposals to quantify the effect of uncompensated care on emergency physician overhead. The RUC is expected to consider the results of HCFA's own uncompensated care analysis in the third and fourth years of the practice expense transition under RBRVS. The Socioeconomic Monitoring System staff of the AMA also is acknowledging the need for questions to

capture the cost of uncompensated care in its future survey process.

There are, however, two immediate threats to the economic gains associated with HCFA's recognition of practice expense. The first is the agency's concurrent offensive against overpayments by Medicare and Medicaid providers. The second is the massive migration of both Medicare and Medicaid to third-party contracting under managed care.

A recent audit of HCFA revealed that \$23 billion was "inappropriately spent" on services to Medicare beneficiaries. A large percentage of this amount was based on inadequate medical record documentation to support the medical necessity and/or level of service billed. HCFA was charged with creating stronger documentation guidelines for easier identification of appropriate levels of service provided when auditing a medical record. The Office of the Inspector General and the Department of Justice are actively seeking fraudulent activity using the documentation guidelines. Allegations of fraud and abuse by the federal government are of increasing concern to all physicians, including ACEP members. Government investigators are aggressively seeking settlements on charges of fraud by emergency physicians. One such case went to trial recently. The issues as detailed in the decision of the Emergency Physicians Billing Service (EPBS) case are summarized here.

Almost four months after the trial ended, US District Judge Robin J. Cauthron released her memorandum opinion. The case was heard without a jury. The action alleges a right to recover under the *qui tam* provisions of

the False Claims Act. The case centers on the 1992 changes in HCFA requirements for claims procedures, with the introduction of the evaluation and management services concept for physician non-procedural services. Reimbursement for evaluation and management required documentation of performance of history, physical examination, and medical decision making. Certain thresholds were established to qualify for a stated level of service. The allegations against EPBS stated that it based its coding on services rendered rather than action documented.

The False Claims Act states that "any person who knowingly presents, or causes to be presented to an officer or employee of the US Government...a false or fraudulent claim for payment or approval is liable to the US Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the government sustained for each claim."

After this suit commenced, audits were performed on EPBS billing practices for the following payers: Xact-administered Medicare (Pennsylvania), Medicaid in Oregon and Arizona, CHAMPUS, and Mailhandlers Federal Employees Health Benefits Programs. The court found these audits to be insufficient to constitute a statistical sample of the universe of fraudulent claims. Concerns about the reliability of the auditors or circumstances under which the audits were undertaken made the Court unwilling to extrapolate the findings to all other claims. The Court therefore relied on the testimony of the defendant's expert witnesses to deem a given claim as false.

The Court concluded that there was a right to relief in some, but not all of the plaintiff's False Claims Act claims. The submission of the following claims was found to violate the False Claims Act: All level 3 claims after 1993; claims for levels 4 and 5 followed by "-52" during 1992 and 1993; Oregon claims including Sunday/holiday/after hours codes after June 17, 1992; and inflated claims found in the five audits prepared in conjunction with this lawsuit.

J.D. McKean and EPBS were determined to be jointly and severally liable for these false claims, the number of which will be determined at the damages hearing. Calculations based on these findings will be presented at the damages hearing. A settlement in principle has been reached between the parties, but the details have not been released.

Other emergency physicians are facing similar allegations of fraud and are being pressured to settle for substantial sums. The Office of Inspector General and Department of Justice have been using questionable tactics in collecting money from medical groups suspected of upcoding. Several groups report receiving a letter estimating the amount of upcoding and offering a settlement amount without ever having audited a single claim. The implied threat is that

failure to settle for the stated amount now would likely result in an audit that could produce much greater penalties. Many groups have paid the settlement amount rather than risk a full-scale audit of their charts. In the EPBS case cited above, the government claimed every level 3 service billed after 1994 was fraudulent based on a change that may have made certain claims inappropriate. It is a stretch to assume that every claim would fall into the questionable category.

THE ELIMINATION OF MEDICARE/MEDICAID COST SHIFTING UNDER MANAGED CARE

The success of managed care during this decade in reducing the rate of inflation in health care costs for employer-sponsored programs prompted state and federal governments to privatize Medicare and Medicaid by contracting with health maintenance organizations (HMOs). Approximately 25% of the nation's 39 million Medicare beneficiaries are now enrolled in HMOs. An even larger percentage of Medicaid beneficiaries have been transitioned to HMOs through contracting at the state level. As a result, potential gains associated with HCFA's recognition of the uncompensated care in fee-for-service emergency physician reimbursement are undermined. Although emergency services are within the scope of benefits included in managed care contracts between HCFA and state health agencies, HMOs are not required to use the RBRVS fee schedule as the basis for payment of emergency physician or ED claims. And because few HMOs directly operate or staff EDs, disputes regarding the medical necessity and relative value of emergency services are inevitable.

Certain HMOs and managed care organizations take advantage of the EMTALA mandate by denying claims retrospectively knowing that the physician had to provide the service or face severe penalties. They do so by either retrospectively denying a claim or by down-coding the service to a "screening fee" payment based on a final diagnosis that does not appear on a pre-approved list of bona fide medical emergency conditions. Often the claim form captures only the final diagnosis, or the carrier refuses to consider presenting symptoms to justify medical necessity for emergency services. A patient in a certain profile complaining of chest pain has to be considered to be having a cardiac emergency until diagnostic testing proves otherwise. If the final diagnosis is something less urgent, carriers deny the claim or pay a small screening fee of \$20 or less. The physician, however, must see the patient and provide at least a screening exam to determine the presence or absence of an emergency medical condition or face EMTALA fines.

State Governments And The Safety Net

State Legislative/Regulatory Committee

Susan Nedza, MD, FACEP, Chair

Ken King, CAE, ACEP Director of State Legislative and Regulatory Activities

Although state and national policy has focused on expanding health insurance coverage for the uninsured for the past ten years, the uninsured population continues to grow. The latest estimates from the US Census Bureau indicate there were about 43.4 million Americans without health care coverage in 1997--1.7 million more than in 1996. Over 18% of the US population is now uninsured. Traditionally, people without health care coverage tend to receive care from hospitals and other publicly oriented providers, and the cost of their care is shifted to other public and private payers. Changes in the health care system, particularly the growth of managed care and for-profit hospital chains, make it increasingly difficult to provide for the uninsured in this manner.

Strategies that states have followed to care for the uninsured have relied heavily on approaches developed in a hospital-centered era. State lawmakers now must adapt these strategies to a managed care environment. Most state strategies are currently designed to shore up the *status quo*.

States with Highest Rates Of Uninsured

Arkansas.....	28.2%
Arizona.....	27.9%
Texas.....	26.7%
New Mexico.....	25.2%
California.....	23.8%
Florida.....	23.7%
Mississippi.....	22.6%
Louisiana.....	22.2%
Montana.....	22.1%
West Virginia.....	20.6%

Their aims are modest and in the final analysis they cannot stand alone. The strategies fall into four broad areas:

- Gathering information about safety net needs
- Requirements to provide care
- Safety net support funds or programs and reimbursement rates
- Managed care and uncompensated care

INFORMATION ABOUT SAFETY NET NEEDS

The first step in addressing the cost of maintaining the safety net is understanding the size of the problem. Data usually are collected only from hospitals, although care is provided in other places. States may collect such data as part of existing reimbursement or regulatory systems or may sponsor the creation of independent or quasi-governmental agencies to gather health care utilization and cost data. Although more than 40 states are working on or have established data collection systems for a variety of purposes, most rely on information gathered from the American Hospital Association's annual survey of hospitals for data on uncompensated care. Twenty states explicitly define charity care, uncompensated care, or other related terms for purposes of cost reporting. However, the definitions vary by state and by hospital.

REQUIREMENTS TO PROVIDE CARE

Federal Emergency Medical Treatment and Active Labor Act (EMTALA) regulations require hospitals to provide emergency care, regardless of ability to pay, as a condition of reimbursement under Medicare. Many states have laws that require providers to give emergency care. Illinois

further requires that each hospital have an emergency department, so that the requirement may not be avoided simply because emergency care is not available. Hospitals financed under the federal Hill-Burton program are required to provide indigent care for 20 years, but in most areas these requirements have now expired. States and localities also use licensure, the certificate of need process, anti-trust, bonding authority, and the tax code to encourage hospitals to provide safety net protections.

SAFETY NET FUNDS OR PROGRAMS AND REIMBURSEMENT RATES

Many states make direct payments to hospitals and other providers for care rendered to certain indigent groups. There is a wide variety of these types of efforts, including publicly funded hospitals and health systems, general assistance medical care reimbursement, uncompensated care pools, and higher reimbursement rates or special payments to disproportionate share hospitals. Much of this funding is now directed to insurance-like products rather than reimbursement pools for hospitals, as was common in the 80s. With the advent of Medicaid Disproportionate Share Hospitals funding expansion in the late 80s and early 90s, most states with uncompensated care pools converted them to the Medicaid program to draw on federal matching funds. Publicly funded hospitals and essential providers are now under new financial pressures as a result of managed care.

One approach to funding safety net services is to formalize cost shifting by including indigent care in the calculation of allowable rates or premiums in states where the government regulates these charges. Maryland is the only state with an all-payer rate setting system. The state includes indigent care in its calculation of rates that hospitals may charge.

Most uncompensated care pools have been merged with state Medicaid Disproportionate Share Hospitals programs. In Massachusetts, each hospital is reimbursed for bad debt and charity care expenditures from the uncompensated care pool. Although the uncompensated care pool is funded primarily through a provider tax on hospitals, a portion of the funds is paid out to community health centers that serve the uninsured. Funds also are derived from assessments on insurers, Employee Retirement Income Security Act plans and private payers. Each hospital's liability to the uncompensated care pool is based on its private sector charges and liabilities. The state's Medicaid Section 1115 waiver includes a program to subsidize employer-provided insurance that is funded from the uncompensated care pool.

MANAGED CARE AND UNCOMPENSATED CARE

As the market becomes more competitive, some state lawmakers and policy experts are asking whether health

plans should be required to assume a certain level of responsibility for maintaining the health care safety net. States are just beginning to set policy in this area. Minnesota alone requires that all managed care plans be nonprofit, which can be used to create an obligation similar to the community benefit requirement for hospitals. However, as managed care and public spending cuts squeeze hospitals, states are discovering that one item that is frequently cut is safety net care. The traditional safety net in health care relies on mission-oriented community hospitals. In the current market, vertically and horizontally integrated groups--health plans and hospital chains--increasingly displace community providers. States are beginning to grapple with adapting old strategies for safety net care to this new environment.

EMTALA requires EDs to screen and stabilize patients with emergency medical conditions. This law applies to any provider that accepts Medicare reimbursement. Nineteen states have similar laws, either as a condition of licensure or as a condition of being reimbursed by other state programs.¹ Most state laws, like the federal law, apply only to those in need of emergency medical treatment or who are in active labor; hospitals can, in theory, avoid these problems by closing their EDs. As mentioned above, Illinois requires that each hospital have an ED as a condition of licensure.

Some states extend the safety net beyond emergencies. Maine, Massachusetts, Michigan, and New Jersey have laws that either require hospitals to provide all needed hospital care to those whose income is below the poverty level or prohibit them from denying hospital services based on ability to pay. In addition to EMTALA, New Jersey has a statutory requirement mandating that all hospitals provide care to individuals regardless of their ability to pay. A hospital that violates the clause may be fined up to \$10,000. The provision is supplemented with a patients' bill of rights for hospitals that stipulates that people who are admitted have the right to treatment without discrimination as to race, age, religion, sex, national origin, or source of payment.

One dynamic area of safety net funding is conversions and mergers between nonprofit and for-profit hospitals in which state attorneys general can play an important role in adapting existing law. For example, the Massachusetts attorney general has aggressively maintained community benefits in negotiations over mergers and conversions of hospitals. A 1996 agreement with MetroWest Health, Inc. and Columbia/HCA Health Care Corp. on the terms of their proposed for-profit partnership included safeguards to protect both charitable interests and local health concerns, and was designed to ensure that the transaction is in the public interest. Protections secured by the attorney general included the following:²

- A commitment to keep EDs on hospital campuses open on a 24-hour basis for at least three years.
- At least \$30 million in sale proceeds to be available for use by a charitable foundation to be established in the two hospital areas. The charity also will receive profits from the partnership.
- Changes to ensure that MetroWest's \$17 million investment is protected and the charitable foundation receives a reasonable return on its investment.
- Capital improvements to be made to both hospitals.
- An independent health care access analysis, funded by MetroWest, to monitor and report as a matter of public record on community health access, including levels of free care, for three years.
- An agreement by Columbia to provide an annual community benefits report to the attorney general on the same voluntary basis as other hospitals.
- A strengthening of local participation in the governance of the partnership.

As states struggle to adapt to the rapidly changing health care environment, no single strategy has emerged to guide them in maintaining the safety net. Most states collect data, although it may be of limited usefulness in responding to the changes, because it is geared to a hospital-based, fee-

for-service system. States also are concerned about how market changes affect access to care but are acting slowly because they do not know how the new marketplace will react. States follow at least three long-standing approaches to assure care: mandates to provide care, regulatory and financial incentives, and direct reimbursement for care.

In summary, most state safety net policies are patches--continuations or adaptations of former approaches that have been given new urgency by changes to the system. During the 90s, most states, like the federal government, considered and then retreated from comprehensive health care reform efforts that would have assured at least minimal universal access. Most state legislatures are alert to the safety net care problem, but no single strategy for assuring care in a health plan-driven market has emerged to replace the assortment of hospital-centered laws. The challenge to states entering the new millennium is how to adapt to a rapidly changing health care system while ensuring that no one is pushed out of the system altogether.

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Health Care Tax Law

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TAX ISSUES AFFECTING INDIVIDUALS

Exclusion from Gross Income for Reimbursement of Health Care Expenses

The Sixteenth Amendment to the United States Constitution grants to Congress the power to tax "income from whatever source derived." Section 61 of the Internal Revenue Code implements and echoes this Constitutional grant of power by defining gross income using the identical words. The US Supreme Court has further expanded on this broad definition by explaining that the taxable base can be any "accessions to wealth, clearly realized ... over which the taxpayers have complete dominion." *Commissioner v. Glenshaw Glass*, 348 U.S. 426, 431 (1955).

Notwithstanding this expansive scope of taxing power, Congress has excluded from the tax base certain items of income that would otherwise clearly meet the broad constitutional definition of that term. Three of these items involve payments designed to compensate the taxpayer for health care-related expenses. Section 104 of the Internal Revenue Code (IRC) excludes from gross income amounts received as compensation for injury or sickness. Section 105 excludes payments made on behalf of a taxpayer for medical expenses. Section 106 excludes employer contributions to a health insurance plan for employees. Each section is described in more detail below.

Section 104 excludes from gross income payments made on behalf of a taxpayer on account of injuries or sickness. These include workers' compensation payments, damages received for physical injuries or sickness (but not including punitive damages), payments received through health insurance plans, payments received on account of injuries

sustained in the armed services, and payments received on account of injury sustained by a US government employee in a terrorist attack.

The most common example of the operation of Section 104 is when a taxpayer receives a settlement as the result of a lawsuit. For example, if a taxpayer is injured in an automobile crash and incurs \$100,000 in medical expenses and recovers that amount in a lawsuit against the driver who caused the accident, the \$100,000 is excluded by operation of Section 104. Although relatively straightforward, the most significant tax law issue presented in Section 104 is the exclusion for "damages ... received ... on account of personal physical injuries or physical sickness." IRC § 104(a)(2). By inclusion of the word "physical" twice in the statute, Congress has clearly chosen to exclude from the exclusion (that is, to include in gross income) compensation for "emotional distress." In addition, it is clear from the statute that punitive damages in tort settlements are not excludable. Thus, only settlement amounts that represent compensation for physical injury or sickness may be excluded; the taxpayer is subject to tax on punitive damages, as well as damages related to emotional distress.

Section 105 permits a taxpayer to exclude from gross income any amounts received as reimbursement for expenses incurred for medical care on behalf of the taxpayer, spouse, or dependents. In addition, short-term disability payments are excludable from gross income so long as they are not calculated by reference to the length of time the taxpayer is out of work. The exclusion will not apply, however, if payments are made on behalf of highly

compensated employees under a "discriminatory" medical expense reimbursement plan – that is, a plan that provides benefits to some, but not all, employees.

Finally, by operation of Section 106, a taxpayer may exclude from gross income payments made by an employer to a health insurance plan on his or her behalf. Payments made on behalf of a small employer for medical savings accounts for employees also are generally excludable from income under this section. In addition, certain payments through flexible spending arrangements for long-term care expenses can be excluded under IRC § 106.

Deductibility Of Medical Expenses

Taxpayers may deduct expenses incurred for medical care in determining their taxable income.¹ The deduction is available only for expenses not reimbursed by insurance or otherwise and only for expenses that exceed 7.5% of the taxpayer's adjusted gross income. IRC § 213(a). The term "medical care" is defined as payments made for "the diagnosis, cure, mitigation, treatment, or prevention of disease." IRC § 213(d)(1)(A). In addition to expenses incurred for medical care, a taxpayer also may deduct expenses for transportation and lodging incurred for the purpose of receiving medical care, for health insurance premiums, and for some long-term care services. Expenses for prescribed drugs and insulin also qualify for the deduction.

Deductibility Of Health Insurance Premiums For The Self-Employed

We have seen that a taxpayer may exclude from gross income payments made by an employer for the taxpayer's health insurance benefits. Self-employed individuals also may claim a tax benefit for expenses they incur in purchasing health insurance for themselves, but that benefit is not as generous as the broad exclusion allowed under Section 106.

Under Section 162(l), a self-employed individual may deduct a portion of the health insurance premiums paid for a policy on the person's behalf. Between 1999 and 2001, such a self-employed taxpayer may deduct 60% of the insurance premium paid. In 2002, the percentage increases to 70%; by 2003, 100% of the amounts paid are allowable as a deduction. The deduction cannot exceed the taxpayer's income for the year. In addition, to prevent a double tax benefit from accruing to a taxpayer, expenses allowable under Section 162(l) cannot be treated as medical expenses under Section 213.

Medical Savings Accounts

Congress, amid some controversy, created a new itemized deduction as part of tax legislation enacted in 1996. Under Section 220 of the IRC, a taxpayer may deduct amounts contributed to a "medical savings account." This account is created for the purpose of paying qualified

medical expenses of the account holder. Congress limited the number of individuals who can claim the deduction for medical savings account to 525,000 per year. In addition, after a "cut-off" year (which is generally expected to be calendar year 2000), new medical savings account enrollees may not claim the deduction.

To qualify for special tax treatment, the taxpayer claiming the deduction must be enrolled in a "high-deductible health plan." A high-deductible health plan has a deductible of between \$1,500 and \$2,250 (\$3,000 to \$4,500 for family plans), and a limit on out-of-pocket expenditures of \$3,000 (\$5,500 for family plans). The taxpayer must either purchase the plan on his or her own (but may not be self-employed) or receive coverage through a small employer. Small employer is defined in the statute as an entity that employs fewer than 50 people.

Distributions from a medical savings account are not taxable to the account holder if used for medical expenses (as defined in Section 213). If funds from the medical savings account are used for other purposes, the account holder must include these amounts in income and is subject to a 15% surtax. Like a pension plan or an individual retirement plan, earnings on the account itself are exempt from federal income tax.

Aside from the complexity of the medical savings account rules, these accounts are also controversial because, some have argued, the tax benefits tend to favor upper-income, healthier workers who are subsidized through the income tax system to exit the traditional health insurance market by purchasing the high-deductible accounts. Under this criticism, as healthier workers leave the traditional insurance market, sicker workers remain. This, in turn, is predicted to increase insurance premiums in the traditional market, leading employers to terminate coverage and possibly increasing the number of uninsured.

Health Insurance Continuation Coverage Requirements

In 1985, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA). Although COBRA was notable for containing the first iteration of the federal EMTALA statute, it contained other provisions as well. One provision imposed tax penalties for the failure of group health insurance plans to provide "continuation coverage" for certain beneficiaries of group health plans. These continuation coverage provisions, now codified at § 4980B of the IRC, impose a \$100 per-day penalty for each day that a plan is out of compliance with the statute.

Under the statute, if an employee experiences a "qualifying event" that would otherwise cause the employee or a beneficiary under the plan to lose health insurance coverage, the employee's group health plan must offer continued coverage for a specified time period. These items constitute a "qualifying event" under the statute: the employee's death, the employee's termination of

employment (except for "gross misconduct"), the bankruptcy of the employee's employer, the divorce of the employee, a child of the employee attaining age 18, and the employee becoming eligible for Medicare.

The continuation coverage requirements of COBRA permit the plan to charge the beneficiary of the continuation coverage provisions a premium equal to 102% of the plan's cost of providing the benefit. Thus, there is no requirement that the employer continue to subsidize the cost of coverage, even if the employer subsidizes coverage for current employees.

The period during which the continuation coverage provisions are effective depends on the "qualifying event." In most cases, the period is 36 months, although it is only 18 months for people whose employment has been terminated. If the beneficiary of the continuation coverage provisions is determined to be disabled under the Social Security Act, the period of continuation coverage is 29 months. Whatever the applicable period, at the end of that time, the employee must be given the option to convert to any conversion health plan otherwise available.

The obligations of a plan under the COBRA continuation coverage provisions terminate if the beneficiary fails to pay any applicable premium. In addition, if the employee becomes covered under another group health plan, continuation coverage ceases. Finally, if the employer ceases offering a group health plan to all employees, the obligation ceases.

TAX ISSUES AFFECTING NOT-FOR-PROFIT HEALTH CARE ENTITIES

Exemption From Tax For Not-For-Profit Hospitals

The vast majority of hospitals in the US operate in not-for-profit form.² The implication of this status is that hospitals are exempt from federal income, but not excise or employment taxes. This exemption applies as long as the hospital is operated "exclusively ... for charitable ... purposes." IRC § 501(c)(3).

In the early years of the federal income tax, the IRS provided no guidance or further definition of the term "charitable purposes." That changed in 1956, however, when the IRS promulgated Revenue Ruling 56-185, 1956-1 CB 202, which held that, as a condition of tax exemption, a hospital was required to provide care for individuals unable to pay for care, to the extent of the hospital's financial ability. The IRS revoked this "financial ability" requirement in 1969 and held in Revenue Ruling 69-545, 1969-2 CB 117 that a hospital must, as a condition of tax exemption, be operated for the benefit of the community.

The 1969 Revenue Ruling remains the condition for tax exemption today. The US Supreme Court upheld that ruling in *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976). Thus, whether a hospital is deemed to be operated "exclusively" for charitable purposes depends on

the more flexible community benefit standard of the 1969 ruling. An explicit "charity care" obligation is not, *per se*, required by the IRS as a condition of tax exemption; rather, the promotion of health and benefit to the community is sufficient.

Central to the IRS' reasoning in Revenue Ruling 69-545 is that a hospital must, as a condition of tax exemption, operate an open emergency department that does not deny care to anyone requiring emergency treatment.³ In testimony before the US House of Representatives in 1991, the Assistant Secretary for Tax Policy of the US Treasury Department testified that a hospital found to have violated the Emergency Medical Treatment and Active Labor Act would be considered to have violated the open ED provisions of the 1969 Ruling. As such, the IRS concluded that such a hospital was not operated for the benefit of the community and, as a result, jeopardized its tax-exempt status. The Treasury Department witness noted that the open ED component of the 1969 ruling was "the ... most important factor demonstrating community benefit."⁴

Revocation of a hospital's tax-exempt status is the "nuclear bomb" rarely, if ever, invoked by the IRS. Recognizing this, Congress in 1996 enacted IRC § 4958, the so-called "intermediate sanctions" statute. Under Section 4958, an excise tax is imposed for each "excess benefit transaction" engaged in by a "disqualified person." In essence, Section 4958 is designed to deter transactions between tax-exempt organizations and "insiders" in the organization; for example, the payment of excessive profits on a no-bid construction contract awarded to a board member who happens to be a contractor. As such, the excise tax is not designed to be invoked as a penalty against a not-for-profit hospital that has failed to meet the "community benefit" standard of Revenue Ruling 69-545. Thus, the only penalty applicable to such a hospital is still, apparently, revocation of tax-exempt status.

Access To Tax-Exempt Debt Financing

Another tax benefit that accrues to a not-for-profit hospital is access to tax-exempt debt. Under IRC § 103, a lender may exclude from gross income "interest on any State or local bond." All 50 States and many local government issuing authorities issue bonds, the proceeds of which may be reloaned to tax-exempt organizations, including hospitals. Interest on such "501(c)(3) bonds" generally can be excluded from gross income if all the bond's proceeds are used to acquire property to be owned by a § 501(c)(3) organization. Because interest on the bonds is exempt from federal income tax, the lender demands a lower interest rate on the borrowing; the lower interest rate, in turn, benefits the § 501(c)(3) organization borrower.

Generally, a bond will not be a qualified 501(c)(3) bond unless the face amount of the bond allocated to a qualified

501(c)(3) organization is \$150 million or less. The \$150 million cap does not apply to a hospital bond, however; qualified hospital bonds may be issued without limit. Thus, hospitals are in a more advantageous position when accessing tax-exempt debt than other not-for-profit organizations.

References

1. In the American income tax system, there are two categories of deductions: deductions *for* adjusted gross income, and deductions *from* adjusted gross income. Examples of the former category are the deductions for alimony and, beginning in 1998, for some student loan interest. Examples of the latter category (more commonly referred to as "itemized deductions") include the deduction for medical expenses, taxes, and home mortgage interest. Generally, it is not to a taxpayer's benefit to itemize deductions unless the total itemized deductions exceed the "standard deduction." IRC § 63(b)(1);(c)(1)(A).
2. See American Hospital Association, "Hospital Statistics, 1998 Edition" (showing 85.2% of acute hospitals in US operating as either government-owned or not-for-profit form).
3. The IRS has since slightly modified this requirement. In Revenue Ruling 83-157, 1983-2 CB 94, the IRS allowed a hospital to be accorded tax-exempt status even though it did not operate an ED because the local health planning agency had determined that operating an ED was duplicative in the community. Similarly, specialty hospitals such as cancer or rehabilitation hospitals are not required to operate an ED. Interestingly, however, some specialty hospitals that do not traditionally operate EDs, most notably psychiatric hospitals, are subject to EMTALA. 42 CFR § 489.24(b); see also 59 Federal Register 119 at 32101 (June 22, 1994).
4. Michael J Graetz: "Tax-Exempt Status of Hospitals and Charity Care Standards," Committee on Ways and Means, US House of Representatives, 102-73, at 34 (July 10, 1991).

Policy Implications For Emergency Medicine

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EMPLOYER-SPONSORED HEALTH CARE INSURANCE

The Employee Benefits Research Institute reported a decline from 69.5% to 63.8% in health insurance rates among workers between 1988 and 1995. Despite the sustained growth in the US economy during the latter half of this decade, the overall percentage of workers with employer-sponsored health insurance is now believed to have dropped below 60%. This is the result of two related phenomena: the strong growth in jobs among small employers and declining health plan enrollment rates among employees.

Because the cost of health care is less predictable for small pools of employees than large pools, smaller firms continue to find fewer health insurers willing to underwrite their benefits and higher premiums for the same coverage offered larger firms. In a General Accounting Office study, small firms also cited higher administrative costs, more frequent employee turnover, and lower profitability as reasons for not offering health care benefits.¹ A recent UCLA/KPMG study reported that more than 90% of all firms with more than 200 employees continue to offer health care benefits to their employees. Although smaller firms remain much less likely to do so, the proportion of those offering benefits increased from 1989 to 1996. Among those with fewer than nine employees, the rate rose from 43% to 51%. Among those with 10 to 24 employees, the rate rose from 72% to 78%.

The drop in employee enrollment in health care coverage despite an expansion in the number of firms offering benefits points out that "market-driven health care

reform" has failed to make insurance more affordable. In addition, the cost of health care benefits appears to be a more limiting factor for many working Americans without health insurance than availability of employer-sponsored programs. During the UCLA/KPMG study period, the percentage of enrolling employees dropped from 79% to 70% among firms with more than 200 employees and slightly more in smaller firms. To contain rapidly rising health care costs during this period, employers in many parts of the country rapidly abandoned indemnity and preferred provider organization plans in favor of various kinds of managed care products. Employees who opted not to enroll in employer health care programs did so because of increasing employee share of costs for benefits, decreasing access to health plans with choice of providers, greater exclusions of pre-existing conditions, longer waiting times for eligibility, and less coverage of temporary workers.² As the UCLA/KPMG analysts noted, "the very actions that employers have increasingly taken to protect themselves from rising health care costs appear to be driving more and more employees to not accept health care insurance coverage offered them." Given that 21 million of 22 million new jobs created in the US between 1988 and 1995 were in companies with fewer than 100 employees, the disparity in average income and access to health care benefits between large and small employers has been greatly magnified.³

EXPANDING COVERAGE AMONG WORKING PEOPLE

Various methods of increasing the pool of workers with health insurance for themselves and their families have

been proposed. Although a complete treatment of these issues is beyond the scope of this white paper, an understanding of the differences in design and effect of the approaches proposed may shed light on their likely impact on the uninsured and safety net providers.

Tax-Based Programs

These programs indirectly subsidize the purchase of health insurance through deductions from taxable income or tax credits. The deductibility of health care premiums is scheduled to increase from 40% by the self-employed to 80% over the next ten years. The benefit of deductions tends to be limited to those US residents with higher income, among whom health insurance rates are already very high. Tax credits, on the other hand, are applied directly to tax owed and generate greater savings for their beneficiaries. This is even more true when credits become refundable, that is, when the credits result in no taxes being paid at all and cash rebates are provided to beneficiaries. Although more than 100 million citizens file tax returns each year, those with intermittent employment or poor cash flow could be expected to have difficulty applying the tax credits directly toward the purchase of health insurance. Given the likelihood that higher-income persons already have access to health insurance, tax-based systems alone are not expected to greatly expand coverage.

Direct Subsidy Programs

This type of program creates new purchasing pools for health insurance for those without access to employer-sponsored programs. Fourteen states already operate insurance programs with sliding-scale subsidies based on family income, covering one million people in 1996. Some of these programs operate with Medicaid 1115 waivers; others are based entirely on state funds. Almost all provide coverage based on age and income. Almost all operate through managed care organizations (MCOs) that contract with the state's plan administrators to provide a covered set of services. Plans funded under Medicaid waivers tend to cover a comprehensive set of benefits. Plans funded by states alone tend to focus on outpatient services. The State Children's Health Insurance Program, passed as part of the Balanced Budget Act of 1997 and funded through new federal tobacco taxes, is expected to greatly expand the availability of health insurance for children with family incomes too high to qualify for Medicaid. Funds are to be administered through qualifying programs currently being implemented in 48 states.

Medicaid Expansion

The expansion of Medicaid already has been used to include pregnant women and children up to age 6 in families with incomes below 133% of the poverty level. Within three years, all children between ages 6 and 18 in families with incomes less than 100% of the poverty level

will be phased in. Similar criteria could be used to expand coverage for the poorest working adults through multiples of the current qualifying income level. Unlike state purchasing pools, expansion of Medicaid would build on traditional Medicaid infrastructures and provider networks. The stigma associated with the welfare offices and means testing might inhibit those with higher income from enrolling. This is already the case with Medicaid enrollment among children, who have enrollment rates substantially lower than the eligible pool of beneficiaries.

Whether subsidy programs contract directly with managed care organizations or through expansion of Medicaid eligibility, some replacement of private dollars with public dollars can be anticipated as the upper limits of income eligibility are reached in subsidy programs. Experts believe this "substitution effect" would be less prominent with subsidy programs than with tax-based incentives. As Glied concluded in a recent Kaiser Foundation assessment of strategies for expanding coverage:

The uninsured today are a large, growing, and diverse population. No single option for incremental reform will fit uninsured people across all incomes. If incremental reform is to reach most uninsured people, multiple reforms will have to be implemented simultaneously. To be effective, these reforms must be designed so that they actually provide coverage to the populations they are intended to serve.⁴

LOCAL AND REGIONAL POLICY INITIATIVES

If, as Tranquada suggested in his commentary on the near-collapse of LAC/USC, all politics are local, then so are the remedies for emergency departments within regional safety nets that are threatened by recent changes in health care. ED saturation recently has been reported as a major problem in Delaware, Maryland, Texas, California, and elsewhere.⁵ During the peak of the influenza season in 1997-1998, diversions of ambulance patients away from saturated Kaiser facilities in California were cited by the health plan as one of the chief causes of their \$276 million dollar losses for the year. ED saturation is one of the clearest indications of the systemic problems hospitals face as a result of the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that assure that services provided will outstrip revenue. In turn, ED saturation leading to emergency medical services diversions is one of the clearest threats to the safety net for *all* US residents. Although the causes can be traced to changes in the economics of health care delivery, safety net providers must search for solutions more rapidly than fundamental reforms are likely to occur.

The concurrent problem with ED back-up panels in many areas is an example more amenable to local solution. Metropolitan EMS jurisdictions typically define criteria that

requires paramedic receiving centers make available nearly every medical and surgical specialty in order to receive "basic" status. This was reasonable when community facilities operated independently of one another, as was the case when most major EMS systems were constructed. But consolidation among private hospitals has proven to be the most powerful trend within that health care sector, in part as a response to the appearance of large-scale public companies operating for-profit hospitals within their communities. By and large, local EMS agencies continue to focus on certification of EMS providers and hospital facilities rather than taking a proactive role in assuring that hospital consolidation does not threaten the availability of timely emergency services, including specialty care. In many cases, the ability of local EMS agencies to think more globally about the service needs in their communities has been hampered by turf battles among EMS providers brought on by the higher rates of uninsurance found in lower-income areas.

In many metropolitan areas, the combined effect of ED closures, downgrades, and hospital consolidation has been the creation of a small number of hospital systems. Los Angeles County is one of the first EMS jurisdictions to begin to think strategically within this new context.⁶ EMS planners elsewhere would be well served by shifting their focus from requirements of individual paramedic receiving centers to negotiations with emerging hospital networks. This would take into account two important realities. First, many hospitals are already actively engaged in subsidizing some ED back-up specialties, such as neurosurgery, and would logically prefer to contain these costs on a systemwide basis. Second, representatives of the Health Care Finance Administration (HCFA) regions charged with enforcing EMTALA have chosen not to intervene in patient transfer policies of local EMS jurisdictions. Inevitably, reductions in the scope of ED back-up services available at a given facility would lead to increased numbers of post-stabilization transfers when patients arrive by private transportation at a location where, for example, invasive cardiac care is not available. Although this may create concerns regarding liability under EMTALA, these could be addressed by EMS agency clinical policies, transfer agreements between "integrated" EMS facilities, or explicit HCFA interpretive guidelines identifying such practices as non-discriminatory.

In many cases, integrated solutions within metropolitan areas will require collaboration (if not consolidation) of EMS agencies themselves. The concept of nonprofit EMS authorities spanning several cities or counties with binding authority over the deployment of out-of-hospital and hospital resources was one of the key findings of a statewide strategic planning process in California, where many safety nets are currently threatened.⁷

There are obvious limits on the extent to which

problems with ED back-up panels can be mitigated by concentrating specialty services within a smaller number of facilities. Any safety net facility serving an area with large numbers of medically indigent patients can expect to have more severe problems over the next few years as the numbers climb, and the conversion of federal health care programs to managed care continues. There is growing evidence that stabilizing back-up panels can be accomplished with a business model as old as emergency medicine: billing agreements between hospitals and their voluntary back-up panelists guaranteeing them a certain percentage of established fee schedules, with hospitals subsidizing shortfalls in actual collections. Given that the unfunded EMTALA mandate arises from threats to Medicare/Medicaid provider status, there is a certain justice to guaranteeing part-time, voluntary members of medical staffs serving on ED back-up panels something between prevailing Medicaid, or more typically Medicare, allowable rates. (It is no small irony that in most cases, emergency physicians themselves are excluded from such guarantees, which largely disappeared from service agreements between emergency physicians and hospitals during earlier cycles of hospital revenue contraction.) The obvious problem arises when payments from other payer classes for ED and inpatient services do not allow such guarantees to be fully cross-subsidized. Direct payments from hospitals to non-employed physicians for professional services provided in the same facility would also appear to raise the possibility of violation of Stark II, which prohibits physician inurement by hospitals participating in Medicare.

Some safety net facilities are beginning to use ED medical directors as billing agents on behalf of their own back-up panels. Typical arrangements call for specialists to assign billing rights for all patients seen or admitted through the ED services in exchange for guaranteed rates of return, for example, 100% of the Medicare allowable. ED medical directors then contract with billing companies to provide billing and collection services on behalf of the back-up specialists. Payments from hospitals typically structured as stipends paid to ED medical directors are used to supplement any shortfalls from the billing and collection process. The use of ED medical directors as intermediaries whose hospital compensation is based on their administrative obligations would appear to obviate any potential claims of inurement of back-up panel specialists by the hospital. In other cases, hospitals are asked to pay "standby costs" for back-up panel specialists in exchange for their willingness to take ED call, regardless of whether professional services are actually rendered.

Although such arrangements may be in conflict with the current HCFA trend of curtailing reassignment of billing and collection rights to agents, as well as the issue raised with Stark II, they have several positive attributes within

the current environment. In terms of both tax status and access to indirect sources of revenue to support charity care, hospitals are currently better structured to cross-subsidize services provided by non-employee physicians on ED back-up panels than any other professional entity. Without statutory changes in the Disproportionate Share Hospital program, for example, this will continue to be true. In addition to improving the access of all ED patients to quality specialty services, such programs would tend to stabilize the business relationships between emergency physicians and the sponsoring facility. Emergency physicians might also expect a higher degree of collegiality with back-up panel specialists, who in turn could be expected to provide more timely responses to ED requests. Perhaps more importantly, such affiliations among professionals practicing within safety nets would allow a stronger bargaining position in future negotiations with MCOs in the same market for emergency and specialty services.

STATE POLICY INITIATIVES

In the absence of fundamental health care reform, most of the immediate opportunities to close the funding gap created by the EMTALA mandate exist at the state level. This is especially true of the newest federal entitlement, the Children's Health Insurance Program (CHIP), to be administered by individual states. Beyond CHIP lie two complementary categories: expanding health insurance coverage for working adults and developing sources of direct reimbursement to safety net providers for uncompensated care. Direction for other states can be sought from examination of the prominent efforts to expand access to insurance in Oregon, and to compensate direct losses associated with charity care in California.

THE OREGON EXPERIENCE

In the late 80s, faced with 18% uninsurance rates, rising costs for both public and private-sponsored health care programs, and a sagging economy, Oregon embarked on a series of reform initiatives. The role played by Dr. John Kitzhaber, an emergency physician who rose from the state senate to governor during the same period, cannot be understated in its importance to Oregon or members of the College elsewhere. The programs implemented over several years included:

- Health care insurance purchasing pools for small employers and individuals with pre-existing medical conditions.
- Replacement of the standard Medicaid benefit package with one based on a community-driven, priority-based program.
- Expansion of Medicaid coverage to all residents with incomes less than 100% of the federal poverty level.
- Subsidies for low-income families for health insurance

premiums.

In a recent self-assessment of the Medicaid Demonstration Project, the reforms implemented since the state received its controversial 1115a waiver from the federal government were shown to "have been largely successful at meeting (their) major goals."⁸ That the state still has an 11% uninsurance rate speaks to the complexity of the challenge. Medicaid enrollment rates actually peaked in 1996 at 94% of eligible beneficiaries and have been declining since. Safety net clinics were subject to increasing demand during the same period, especially in rural areas. The state's concern about the condition of outpatient safety net facilities was pointed out by a recent allocation of \$3.5 million to shore them up financially, and commission of an actuarial analysis of their operations by Milliman and Robertson.⁹ By understanding the successes and failures of reform efforts in Oregon, safety net providers in other states may find guidance in their own efforts to reverse rising rates of uninsurance.

Although the most widely reported aspect of the state's efforts focused on substitution of the standard Medicaid benefit package with a community-driven list of prioritized services, other principles were just as important. Kitzhaber and others understood that eliminating the cost-shift between public and private payers would make health insurance more affordable in the private sector. This could be accomplished only by recognizing that underpayments by Medicaid programs are as significant to providers as those associated with charity care to the uninsured. Although payments now equate to only 65% of commercial rates in Oregon, this still exceeds estimates of national trends, which are variously reported at 45% to 55% of costs.

A related ethic held that it was more socially responsible to ensure universal access to health care services, such as immunization and preventive care, where consensus exists, than to offer wider arrays of services to a smaller population of beneficiaries. The state was able to fend off accusations that prioritizing health care service benefits amounted to rationing or that excluding certain types of care for victims of terminal or irreversible diseases was discriminatory, although these disputes did delay the federal 1115a Medicaid waiver in 1992. Perhaps most importantly for the continuing national debate about EMTALA mandates and the obligations of payers regarding screening and stabilization services, the Oregon plan held that diagnostic services needed to establish whether treatment of a medical condition was a covered benefit would always be covered. Thus, safety net providers had no reason to fear that payment for such services would be subject to retrospective denial or disputes with payers.

The original Oregon Plan included mandates on employers to either offer health care insurance for

employees working more than 17 hours per week or be subject to a payroll tax that would fund the state purchasing pool for small employers. Because of predictable opposition from the private sector, implementation was postponed from 1994 to 1995, and later to 1997, before being eliminated as a result of failure to receive an Employee Retirement Income Security Act waiver from Congress. But the plan was more successful at minimizing crowding out (or substitution) of private-sponsored health care coverage due to expansion of public programs. Much of this was due to a rebound in the state's economy during this decade. Though the crowd-out phenomenon is too complex to address entirely in this white paper, some program elements intended to minimize its effect are common in many states:

- Focusing eligibility on workers with the lowest income ranges, who can be expected to be the least likely to purchase employer-sponsored coverage or work for small employers less likely to offer such coverage. This is reflected in the fact that 11 of 22 states granted Medicaid 1115a waivers are expanding eligibility beyond the income levels of the traditional program, usually expressed as multiples of the federal poverty level.
- Incorporating beneficiary cost-sharing to align the economic interests of payers and patients. Traditionally, the medically indigent status of those eligible for Medicaid largely eliminated the ability to use copayments as they are used in private plans to dampen utilization by beneficiaries. As eligibility is expanded under state waiver programs, sliding-scale obligations of working beneficiaries become a means of reducing crowd-out or perceptions that public-sponsored programs are less costly than those offered by their employers. (Conversely, Oregon has recommended for

such individuals that copayments at the point of service are less onerous than monthly premiums, which appear to be one of the reasons some eligible beneficiaries are not enrolling in the state plan.)

- Extending eligibility periods dampens the effect of frequent changes in employment status or pregnancy, which is a relatively significant issue for Medicaid beneficiaries.

IMPLEMENTING THE CHILDREN'S HEALTH INSURANCE PROGRAMS

The fact that there are 11 million children without health insurance, including four million who are eligible for Medicaid but are not enrolled, is frustrating to safety net providers. There is a high degree of social consensus about the merits of ensuring the healthy development of the nation's children. The federally sponsored CHIP represents a \$24 billion commitment through 2002 to extend benefits to another 5 to 6 million children from households with incomes exceeding Medicaid limits. To date, enrollment has fallen far short of eligible populations, despite the fact that 48 of the 50 states, along with US territories, have proposed or implemented plans. Under the new statute, Title XXI of the Social Security Act, qualifying plans must include coverage for inpatient and outpatient hospital services as well as medical and surgical services by physicians under existing state Medicaid programs, or equivalent commercial plans benchmarked to those offered to federal employees.

The major shortfall to date in enrolling eligible children in state CHIP programs is thought to be the result of several factors. In many cases, working parents may assume their children are not eligible. In others, parents may not wish to associate themselves or their children with welfare programs, when states opt to incorporate CHIP into Medicaid. Language barriers are also thought to come into play when children are part of immigrant families where English is not spoken in the home, or where there may be fears that immigration authorities may be alerted by CHIP. HCFA and the White House expanded outreach programs earlier this year, with public support from ACEP and other advocates of children's issues in the public and private sector.¹⁰ Efforts will be focused on enrollment at schools and other mainstream locations, as well as at the point of service in safety net facilities, and member service locations of contracting private plans. There is little doubt that this represents the single greatest opportunity to stem the rising tide of uninsurance for safety net providers and their patients.

CREATING PROGRAMS TO FUND SAFETY NET SERVICES

The notion of directly compensating providers for their costs has at least two underlying premises. First, the nature of our health care system makes it unlikely we will provide insurance for all citizens any time soon. As the Oregon

Table 1.

Status of CHIPS States/Territories

NUMBER OF PLANS APPROVED: 50

AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, VA, VI, WI, WV

NUMBER OF SEPARATE STATE CHILD HEALTH PLANS: 14

AZ, CO, DE, GA, KS, MT, NC, NV, NY, OR, PA, UT, VT, VA

NUMBER OF MEDICAID EXPANSIONS: 28

AK, AS, AR, DC, GU, HI, ID, IL, IN, IA, LA, MD, MN, MO, NE, NM, ND, OH, OK, PR, RI, SC, SD, TN, TX, VI, VT, WI

Number of Combinations Plans: 11

AL, CA, CT, FL, KY, MA, ME, MI, MS, NH, NJ

Number of Plan Amendments Approved: 12

AL, CA, FL, ID, MI, MS, MO, NE, NC, PA, RI, WI

Number of Plan Amendments Under Review: 11

AR, AZ, CA-2nd, CO, FL-2nd, IL, NH, NJ, OK, UT, WV

example makes clear, the practical limits of statutory expansion of health care benefits appears to be around 90%. The second premise is that health care providers deserve an economic offset for providing charity care that recognizes the marginal overhead needed to support their own practices, employees, and facilities. Congress certainly believed that health care professionals should be expected to render a certain number of *pro bono* services to the medically indigent when it created EMTALA. This is only a modern expression of the same cultural ethic imbued in the work of Constitutional framers, which itself can be traced back to Judeo-Christian traditions. In terms of the health care marketplace of the original Consolidated Omnibus Budget Reconciliation Act, Congress in 1986 might be said to have mandated tithing back to the health care system that sustains them by providing charity care to one out of every ten patients they treated. But on a national scale, EMTALA today approaches a double tithe; an imprecise mandate that selectively punishes the very providers it should be encouraging: those willing to voluntarily render charity care to one out of every five patients less than Medicare age. This is the fundamental inequity of the EMTALA mandate and the reason all Americans have reason to fear for the safety net facilities they rely on for emergency services. Professionals and hospitals need health care policies that will reward them for staffing and operating EDs, not undue financial burdens that force them to abandon EDs and escape EMTALA.

Minnesota recognizes this conflict by using a tax on health care providers to fund uncompensated care. Although anathema to many in health care, it at least represents a more efficient way of covering safety net services, as providers cannot escape the costs by avoiding the delivery of services at safety net facilities. Massachusetts uses a tax on health plans to fund a pool for uncompensated care that can be accessed by hospitals based on the volume of such services they render. To the extent that the insurance industry restricts access to affordable products to meet its own financial interests, there is some degree of social justice in such a system. This must be balanced against the risk that excessive taxation will cause insurers to withdraw from underwriting activities in the state altogether. For ACEP members and their peers on ED back-up panels, the main problem with the Massachusetts program is that only hospitals are qualified to seek reimbursement. Depending on the extent of safety net services in their own community, this would force physicians to seek increasingly exclusive employment arrangements with hospitals that they might otherwise not need or desire.

The largest program to directly compensate safety net providers for their losses has been in operation in California for a decade, generating tens of millions of dollars annually. Emergency Medical Service Funds are based on a different

premise: those who are in part responsible for acute illnesses and injuries should bear some of the burden of caring for their victims. The first phase was enacted in 1987 by enabling counties to reimburse physicians and hospitals providing emergency services to the uninsured for up to 50% of their losses, with funds derived from surcharges on motor vehicle and criminal fines levied by their courts. Forty-three counties, including all the metropolitan areas of the state, established EMS funds, which they were allowed to administer with up to 10% of all revenue in the funds. Subsequent legislation doubled the amount of surcharges earmarked for the funds and attempted to mandate counties to direct revenue into the funds at their level in 1990-1991.

At about the same time, Proposition 99 passed in a statewide ballot initiative, creating a new tobacco tax that generated a second stream of revenue into EMS funds. For both reimbursement sources, EMS fund providers were required to bill uninsured patients three times without receiving any direct payment from the patient, and were precluded from billing counties for patients covered by any other federal health care program. A third initiative, which would have placed an EMS fund tax on alcoholic beverages, failed on a statewide ballot a few years later. This occurred in part because of a ferocious defense by the brewers, distillers, and distributors who were reported to have spent \$65-75 million to defeat it.¹¹

EMS funds have been crucial to maintaining financing for trauma centers and basic ED services in many areas, and on average result in reimbursement rates competitive with those available in California for Medicaid. Unfortunately, the funds have failed to keep pace with the growth in the population without health insurance, now estimated at 7 million statewide and increasing by 50,000 working people per month, despite a major rebound in the state's economy and declining unemployment.¹² Concerns regarding the stability of EMS funds prompted a report earlier this year by the California State Auditor.¹³ The conclusions might be generalized for the sake of leaders in other states who should be encouraged to promote their own community-level sources of funding to offset the uncompensated costs of safety net services:

- Funds should be designed to assure EMS providers that all revenues collected for a given period are maintained in accounts separate from other county funds and fully distributed in the same period. Interest income from revenues, including the portion allocated for fund administration, should accrue to the EMS funds until distributed to providers.
- The benefit of administrative efficiencies that result in less than the full amount of administrative expenses being expended should accrue to EMS providers and the county itself.

- When counties play an important part in operating safety net facilities, their interests must be included in the design of EMS funds, especially if they are also expected to fairly treat community-based EMS providers as administrators of funds.
- EMS funds must strive to align the interests of both cities and unincorporated areas within counties, given that each has been disadvantaged in different ways by the reduction in social programs at the federal and state levels. For example, peace officers employed by cities in California are responsible for the citations that generate court fines, but the cities do not benefit directly from county EMS funds.
- Revenue from within the percentage of EMS funds earmarked for administration must be set aside to assure providers through ongoing statewide audit and review that counties are complying with relevant statutory requirements.
- EMS funds should incorporate standard statewide fee schedules to prevent overpayment based on raw charges alone by EMS providers or underpayment by county administrators. Given the centrality of EMTALA, it is logical to use existing Medicare criteria, such as resource-based relative value scale for physicians and ambulatory patient classification/diagnosis-related groups for hospitals.
- EMS funds should be structured to support (rather than compete with) the need for continuing outpatient care by community clinics that operate beyond the EMTALA mandate but have a more specific commitment to the medically indigent.

FEDERAL POLICY INITIATIVES

The statutory requirements of EMTALA on safety net providers have an effect that extends far beyond screening and stabilization in the ED. The combined efforts of emergency physicians and the specialists that back them up assure that even uninsured citizens will still receive catastrophic health care coverage. As we have shown, the uncompensated costs for hospital-based services under EMTALA may exceed \$25 billion annually. For those who view health care as a public right, EMTALA is a kind of Trojan horse that has been rolled into the marketplace, waiting to overwhelm those who view health care as a private commodity. Yet the conflict over whether health care is a right or a privilege is only part of a much more profound ideological conflict within our culture, as recent events in Washington made painfully clear.

Given the continuing influence of special interest groups on both sides of the health care debate, the current stalemate can be expected to hold for the foreseeable future. But every day that safety net providers continue to provide services to their communities, the ranks of the uninsured grow. Without reform, the weight of uncompensated costs,

coupled with the growth in the number of Medicare beneficiaries, can be counted on to collapse the acute care system. All that remains to be seen is whether the health care debate will be ended by social consensus or crisis within the safety net upon which all US residents rely.

For most of us, voluntary service in the safety net is a matter of personal choice. For such facilities and individuals, we serve not because of EMTALA but despite it. If our primary mission remains providing quality emergency medical care, we must ensure that EMTALA does not prevent us from achieving our professional and institutional goals. This will require that we make policy makers accountable for the EMTALA mandate. The basic principle of cross-subsidizing uncompensated care with revenues from other federal programs was an implicit part of the original COBRA law and must be made an explicit part of EMTALA. Safety net providers must demand that Congress, HCFA, and the President confront the many ways in which other federal health care policies, coupled with market-driven changes in private health care, have largely eliminated the ability of safety net providers to cost-shift. Thus, the immediate focus of ACEP federal health care policy should be to attempt to align incentives between government, safety net providers, and the regulatory process. This would appear to hold more promise in the near term than attempts to promote major statutory reform in the health insurance industry.

EMTALA AND PRACTICE EXPENSE

Few elements of the health care delivery system can lay stronger claim to providing a public good than EMS. In some ways the safety net operates more like other service industries upon which all citizens depend than the rest of health care. Historically, industries that provided essential services to consumers, such as telephone, water, and power, were granted utility status. Like emergency services, many of these industries operated within markets as virtual monopolies and were able to convince regulators that their ability to distribute the fixed costs of their infrastructures across the broadest possible customer base was crucial to their ability to make their services affordable. In exchange for utility status, such industries typically surrendered their ability to independently price their services in exchange for reassurances from regulators that their full costs (and reasonable earnings for shareholders) would be built into approved pricing structures. Although most of these industries are now engaged in fast-paced voluntary deregulation to compete more effectively within the private sector, their example remains relevant to current negotiations between ACEP and HCFA regarding practice expense.

The importance of practice expense in Medicare Part B payments under HCFA's resource-based relative value scale (RBRVS) is evident from the fact that it amounts to 40% of

all professional compensation (\$20 billion). That ACEP should be pleased emergency physicians are expected to receive a 10% reduction in Medicare payments over the next four years speaks of the importance of HCFA's philosophical acceptance that uncompensated care arising from EMTALA is a legitimate practice expense. Although the substitution of the American Medical Association's original practice expense estimate with the all-physician average is only a partial offset for the direct losses of emergency physicians, the precedent should be the basis of the most important federal regulatory initiative for the College in the next few years. In the continuing "refinement" of RBRVS mandated by Congress, ACEP will be the official representative of our specialty in the AMA-sponsored Relative Value Update Committee and the related Practice Expense Advisory Committee.¹⁴

Beyond direct reimbursement for Medicare services, the inclusion of uncompensated care as a legitimate practice expense would further negotiations with other payer classes, who increasingly use Medicare rates as a benchmark in contracting. Further, RBRVS-derived claims data are the primary source of financial information used to establish premiums for prepaid Medicare Part C created by the Balanced Budget Act. In order to secure access to emergency services for all Americans, the same principle must be extended to practice expense estimates for other medical specialties providing back-up and inpatient care to uninsured ED patients. This would help to dampen conflict within the house of medicine as all RBRVS refinement occurs within the context of "budget neutrality." Finally, such modifications of current HCFA policy would obviate the potential need for government regulators to more directly control health care services currently being provided in the private sector. That other industries with official utility status are actively engaged in attempts to escape government regulation should not be lost on those who advocate the opposite for health care.

EMTALA, MEDICARE PART C, AND MANAGED MEDICAID CONTRACTING

Although the inclusion of prudent layperson language in the Balanced Budget Act was a major accomplishment for ACEP, its implementation by HCFA has been delayed and remains problematic for both regulators and safety net providers. Similarly, HCFA has been clear in its intent to extend the protections of EMTALA to beneficiaries of MCOs but ambivalent about the obligation of health plans to pay for the emergency medical screening and stabilization required by the statute.¹⁶ This has led to countless disputes between safety net providers and MCOs regarding claims review and payment processes. As a result, class action suits arising from non-payment for services covered by prudent layperson laws have recently been filed in at least two states.^{17,18}

There are many who believe that at least some MCOs capitalize on the EMTALA mandate by engaging in unfair business practices, leading to excessive numbers of delays, denials, and downcoding. To be fair, it is also true that ACEP has encouraged its members to decline requests from payers to define diagnostic criteria that correlate with what a prudent layperson would, or would not, consider an emergency condition. All of this arises from the fact that emergency medicine, unlike other specialties, is largely complaint-driven rather than diagnosis-driven. In the absence of objective criteria like CPT or ICD coding systems, which both providers and payers could prospectively agree accurately and safely reflect on such conditions, it will be difficult, if not impossible, for HCFA to formulate regulatory language for contracting health plans as required by the Balanced Budget Act.

Most analysts agree that the first phase of managed care has achieved better financial results primarily by changing the incentives of providers. Capitation, for example, has created a powerful incentive to do less for patients than was true under fee-for-service methods of compensation. In the context of EMTALA, it is unreasonable to expect that for-profit health maintenance organizations (HMOs) contracting with HCFA for Medicare under Part C, or with state governments for Managed Medicaid, will be able to resist the temptation to put safety net providers at a disadvantage to further their own financial goals. In simpler terms, it has been said, "the golden rule of managed care is that he who has the gold makes the rules." Few state regulators have shown any willingness to enforce requirements that private MCOs contracting for Medicaid populations subcontract with traditional safety net facilities. Indeed, many would argue that to do so would undermine the ability of states to bring Medicaid populations into the mainstream, a reasonable policy goal.

There is at least one simple and logical approach state and federal regulators could use to assure that contracting plans continue to cross-subsidize uncompensated care with revenues from federal health care programs being transitioned to managed care. HCFA should be encouraged to explore the feasibility of applying a "safety net test" to contracting health plans before allowing them to receive capitation revenue for emergency and related hospital services. State and federal regulators could require HMOs bidding to offer Medicare Part C or Managed Medicaid services to demonstrate that they are actively engaged in providing safety net services through the operation of nonprofit clinics, hospitals, or EDs. In this scenario, ACEP's ally Kaiser would qualify through the operation of its own delivery system, which includes acute care hospitals and EDs. Health plans sponsored by hospital-driven integrated delivery systems, most of whom are nonprofit, also would qualify. Most commercial plans, including nonprofits such as the Blue Cross/Blue Shield Association that have used

global capitation to shift the risk to their provider networks, would not pass a safety net test.

The virtue of consolidating emergency service contracting at the health plan level has been made clear by alarming rates of insolvency among downstream fiscal intermediaries of HMOs. Such smaller-scale MCOs are responsible for delivering covered services to plan members (and reimbursing providers) under the "network models" that prevail in most metropolitan markets. Many safety net providers were affected negatively by the bankruptcy of Sterling/FPA, which in turn prompted the more recent seizure of the California operations of MedPartners by the Department of Corporations.¹⁹ In an ongoing dispute between the California Medical Association and HMOs that previously contracted with Sterling/FPA, the courts will decide whether the fiduciary obligations of plans include financial responsibility for the liabilities of failed subcontracting MCOs.

An incremental approach to safety net regulation for beneficiaries of federal health programs would require a stipulation from contracting HMOs that they subcontract only with safety net providers for emergency services. This would pre-empt the use of financial incentives to induce gatekeepers and plan members to seek urgent care at non-hospital facilities outside the safety net with inherently lower costs. A more aggressive approach would be for state and federal regulators to hold back the portion of the premium associated with emergency services and contract with HMOs for a narrower scope of benefits. Emergency service revenue could be readily "carved out" on the basis of actuarial analysis and claims data. HCFA and state health departments then could designate fiscal intermediaries to process claims for emergency services, just as they continue to do for Medicare Parts A and B and traditional Medicaid in most states.

Safety net pools could be administered through the existing RBRVS system, which is based on global budgets. Beyond the Relative Value Update Committee/Practice Expense Advisory Committee process described above, conversion factors also could be adjusted periodically to assure that pools were not exhausted before the end of a given plan year. Behavioral offsets for upcoding could be accomplished through techniques that have worked well within the managed care sphere for professional specialty services. Under contact capitation, for example, providers are still paid case rates that vary in value for a given period by the number of claims, or contacts, between plan members and contracting providers. Pools are fixed in amount per member per period by the plan (HCFA or state health departments). Revenue per case becomes a simple derivation based on the number of visits. A similar result would occur if providers demanded the right to unbundle professional claims, so long as the pool was administered through periodic calculations of total relative value units

claimed that drove the value of conversion factors.

In any case, safety net providers should reasonably expect that government regulators would demand some protections against gaming of professional and facility claims in exchange for relief from the current MCO gaming of reimbursement. Within a revenue-neutral environment, most of the economic benefit to safety net providers would relate to lower overhead associated with reimbursement and reduction of losses associated with non-reimbursement by MCOs for ED services.

EMTALA AND MEDICARE PART B OVERPAYMENTS

The belief that fraud and abuse are widespread among vendors and providers has become a major focus for HCFA, the Office of the Inspector General, and the Department of Justice. One result was a recent federal judgment against Emergency Physicians Billing Service (EPBS) for allegedly "upcoding" evaluation and management codes billed for services to Medicare beneficiaries. Although the original relater, an ex-EPBS employee protected under federal whistleblower statutes, sought more than \$1 billion in claims, including treble damages allowed when federal contractors are guilty of fraud and abuse, the court held that not all EPBS claims were false. Terms of the actual settlement are still under negotiation between the court and legal representatives for the parties.²⁰

Although the College could be expected to encourage HCFA and the Office of Inspector General to eliminate those guilty of fraudulently diverting Medicare funds from the list of safety net providers, it has equally compelling reasons to defend the unique role emergency physicians play within the safety net. This defense has at least two fronts. Legitimate disputes remain between providers and HCFA regarding some of the vagaries in the current documentation requirements for the five evaluation and management emergency medicine levels commonly used by emergency physicians. These questions can be expected to become more pressing when our emergency medicine levels are lumped into three that drive payments for outpatient ED services under Medicare Part A, currently scheduled for early 2000. Thus, the proposed changes in RBRVS documentation requirements become as important to the safety net facilities where emergency physicians practice as they are to the physicians themselves.

HCFA must acknowledge the special problems in dealing with patients who may not have access to continuing care and who may not share a common language with safety net providers. Regulators also must take into account the severe time constraints on documentation that are endemic in the nation's EDs.

Unlike office practices that provide continuing care to private patients, billing agents for emergency physicians are confronted with special challenges in their attempts to generate consistent, accurate and timely professional claims. Medical records are the property of the hospital and not the emergency physician and may or may not be available for review by billing agents. Hospitals may or may not make available transcription services to emergency physicians. Emergency physicians may or may not have legible handwriting. Because of the pressure to create billing information rapidly enough to allow for electronic order entry and access, and hospital ancillaries necessary for emergency medical screening and stabilization, demographic information may be flawed or absent (as in the common John Doe chart).

For all these reasons and more, it is important for HCFA and the Office of Inspector General to understand that in the vast majority of cases, coding errors for emergency services are not part of some grand criminal conspiracy but are another reflection of the chaotic nature of medical care within safety net facilities. More importantly to those providing services under the unfunded EMTALA mandate, "downcoding," or coding errors that favor HCFA, is as likely to occur in the current environment as errors favoring providers or billing agents. During audits for possible overpayments, federal investigators could recognize this by allowing emergency physicians and their billing agents full credit for errors arising from downcoding as well as upcoding, provided there is no evidence of any systematic attempt to defraud Medicare.

EMTALA AND THE EMPLOYEE RETIREMENT INSURANCE SAFETY ACT (ERISA)

One of the most compelling reasons for prudent layperson legislation to be sponsored at the federal level is that most health plans sponsored by larger employers are, in fact, self-insured. These plans require federal waivers under ERISA to ensure that employee benefits are underwritten adequately and protected to the same degree they would be if provided through commercial insurance companies. In most cases, commercial insurance companies still act as third-party administrators for such employer-sponsored, ERISA-exempt plans. EMTALA already protects employees covered by such plans, and employer-sponsored plans must comply with pertinent federal law to receive a waiver. Although statutory changes beyond those proposed in Cardin might be required, it is reasonable to expect that employers will comply with any realignment of regulatory policies agreed to by the government to support safety net providers under EMTALA. This is most likely to occur if safety net tests were applied to contracting for emergency services by ERISA-exempt plans or if cost-based rates for emergency services were extended from federal health care programs to those requiring federal waivers.

CONCLUSION

As conceived by Congress, interpreted by HCFA, and reviewed by the US Supreme Court, EMTALA is far more than a guarantee of ED screening and stabilization. It is, in fact, catastrophic health care coverage for those US residents without other forms of insurance. As a population, it exceeds the enrollment in Medicaid or Medicare. Unlike other federal health care programs (including those for government employees, veterans, and Native Americans) EMTALA is structured as a mandate on America's safety net providers.

Policy makers have made a bet that until fundamental health care reform is politically feasible, providers will continue to voluntarily render safety net services based on the government's power and influence as the payer for nearly half of all health care costs. To the extent that nearly 100 million Americans continue to receive high-quality emergency medical services care each year, despite the growing gap between mandated costs and market-driven reimbursement, the gamble of federal health care policy makers appears to be paying off. Yet safety net providers, by and large, would argue that they are not serving because of the federal mandate but despite it.

At issue is whether America's safety nets will hold if the larger market forces over which they have no control continue unchecked. The number of working people under the age of 65 without health insurance is expected to reach 20% by 2002. Managed care, despite its current public relations problems, will continue to increase its market dominance as government health care programs shift to control costs, as 85% of employer-sponsored health care plans have. Contraction is likely to occur in the number of facilities and professionals willing to continue to provide safety net services. Wherever the uninsured and underinsured are to be found in disproportionate numbers, problems will continue to mount more rapidly. MCOs operating beyond the EMTALA mandate can be expected to continue to act in their own interests in a marketplace that is, by definition, merciless and amoral. Society must recognize that, like all rights, access to emergency services can be protected only at a price.

It is highly likely that the final resolution of the conflicts surrounding EMTALA will constitute our answer, as a nation, to the question Uwe Reinhardt has raised:

To the extent that our health system can make it possible, should the child of a gas station attendant have the same chance of a healthy life, and the same chance of a cure for a given illness, as does the child of a corporate executive?

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