Received: 28 October 2019 | Revised: 9 March 2020 | Accepted: 25 March 2020

DOI: 10.1002/emp2.12067

JACEP OPEN
JOURNAL OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS OPEN
A GLOBAL JOURNAL OF EMERGENCY MEDICINE
Open Access

WILEY

SPECIAL CONTRIBUTION

Ethics

Ethical issues in access to and delivery of emergency department care in an era of changing reimbursement and novel payment models

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Funding and support: By *JACEPOpen* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

Abstract

Hospital emergency departments (EDs) and the emergency physicians, nurses, and other health professionals who provide emergency care in them, are a critical component of the United States (US) health care system in the 21st century. Although access to emergency care has become a de facto right in the United States, funding for emergency care is fragmented and complex, which causes confusion and conflict about who should bear the cost of care. This article examines the tension between universal access to emergency care in the United States and the fragmentary, tenuous, and contentious financial arrangements that make it possible, viewing the issue in context of the historical development, legal and moral foundations, current situation, and future challenges of ED care in the United States. It begins with a review of the origins and evolution of emergency care and of hospital EDs in the United States. It then examines arguments for a right to emergency medical care and for shared obligations of patients to seek and of professionals and society to provide that care. Finally, it reviews current strategies and future prospects for protecting access to emergency care for patients who require it.

1 | A BRIEF HISTORY OF EMERGENCY CARE IN THE UNITED STATES

Over the past half century, emergency departments have emerged as a prominent feature of the United States (US) healthcare system. As emergency care evolved, its patients, providers, treatments, facilities, and standards of care have undergone significant changes.

The end of World War II ushered in a period of unprecedented growth and change in US health care, marked by rapidly increasing funding for biomedical research, the development and dissemination of new and effective therapies, and major expansion of employer-provided health insurance as a preferred employee benefit.[1] During this post-war era, the United States did not follow the path of the United Kingdom, Canada, and other economically developed nations in establishing health care as a basic right of its citizens. Congress did, however, provide funding for the construction of public community hospitals across the country under the Hill-Burton Act of 1946, and those hospitals typically included "emergency rooms" to improve patient access to care.[2] In 1965, Congress enacted legislation to establish Medicare and Medicaid, major new programs of publicly funded health insurance for the elderly and a portion of the indigent population.[3] The hospital emergency rooms of the 1950s and

Supervising Editor: Nicholas M. Mohr, MD, MS

1960s provided access to treatment for acute illnesses and injuries, but the staffing and quality of care provided in those settings were inconsistent.[2] Hospitals used house staff, if available, moonlighting physicians, and even medical students to provide coverage in their emergency rooms, and there were no dedicated training programs for providers of emergency care.[2] The Emergency Medical Services (EMS) Systems Act of 1973 earmarked federal funding for the development of EMS systems designed to provide prompt life-saving treatment in the field and rapid transportation to the hospital, but the quality of care in hospital units, now called "emergency departments," was still uneven.[4]

Physicians, hospitals, and patient groups all recognized the need to improve the quality of emergency medical care. Pioneer emergency physicians founded a professional society, the American College of Emergency Physicians (ACEP), in 1968.[5] The first residency training program in emergency medicine was established in Cincinnati in 1970, and in 1979 emergency medicine became a board-certified medical specialty.[6] By this time, hospital EDs were the major setting for treatment for emergency medical conditions and also a primary source of routine medical care for indigent and uninsured patients who had no other ready access to care.[2]

Congress formally recognized the role of the ED as the primary safety net for US health care in its 1986 passage of the Emergency Medical Treatment and Labor Act (EMTALA).[7] Responding to reports of the practice of "dumping," the transfer of uninsured and other undesirable patients out of the hospital without regard for their clinical stability, Congress mandated in EMTALA that US hospitals that accept Medicare funding and have EDs must provide all patients who present to the ED with an appropriate medical screening examination and, if the patient has an emergency medical condition, stabilization of that condition, regardless of the patient's inability to pay for treatment. EMTALA also prohibits hospitals from transferring patients to another facility unless they are in stable condition or other specified conditions are met. Congress did not appropriate funding for these services, and so the limited responsibility to provide medical screening and treatment under EMTALA remains an unfunded mandate.

With the emergence of managed care in the 1990s, some managed care organizations denied authorization for treatment of their enrollees in the ED and refused to pay for ED care without prior authorization. In response, the Balanced Budget Act of 1997 required use of a "prudent layperson standard" to determine insurance coverage for ED treatment.[8] That standard defined an emergency condition as any medical condition, including severe pain, which would lead a prudent layperson to believe that the condition required immediate medical care in order to prevent serious health consequences. Around the same time as the Balanced Budget Act, the State Children's Health Insurance Program (SCHIP), now known as the Children's Health Insurance Program (CHIP), was created to provide insurance coverage for families with modest incomes who did not previously qualify for Medicaid.

2 | PROFESSIONAL OBLIGATIONS OF EMERGENCY PHYSICIANS

The events described above, most notably the EMTALA mandate to provide emergency care for all who request it, have created a central role for emergency physicians in the US health care system, both to provide access to care for all comers and to be fiduciaries of health care resources. The "Principles of Ethics for Emergency Physicians," a prominent feature of the ACEP *Code of Ethics for Emergency Physicians*, affirm a moral duty to provide emergency care, with the second of these fundamental principles asserting that "emergency physicians shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care."[9] The *Code of Ethics* elaborates on this duty in its later assertion that "denial of emergency care … on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, type of illness or injury, or ability to pay is unethical."[9] In addition to asserting a moral duty to provide care, the ACEP "Principles of Ethics for Emergency Physicians" also recognizes a duty to allocate finite medical resources wisely, with the ninth principle affirming that "emergency physicians shall act as responsible stewards of the health care resources entrusted to them." The *Code of Ethics* describes responsible stewardship as a dual responsibility to patients and societies to make prudent resource allocation decisions based on the urgency of the medical condition, the medical benefits and burdens for the patient, and the cost to society.[9] This principle affirms another central responsibility of emergency physicians in limiting treatments whose expected costs and burdens clearly exceed their anticipated benefits.

3 | SOCIETAL AND PAYOR OBLIGATIONS

In addition to the duties of individual emergency physicians described above, several powerful and widely embraced moral arguments support a societal obligation to maintain emergency care networks. It is worth briefly reviewing the normative sources of the societal obligation to create and sustain an emergency care infrastructure, and also to consider who bears the obligation to provide these services.

The first normative source of the obligation to provide acute care is not truly a moral precept, but rather a principle of practical reasoning. That is, citizens know there is a distinct possibility that they will be stricken by a sudden illness or serious injury at some point, and that in this situation they will benefit from a well-functioning acute care system. Hence, citizens have a prudential interest in supporting their society's acute care infrastructure. In the United States, this takes the form of EMS systems, government regulation of acute care hospitals (eg, EMTALA and ACA provisions), and support for public hospitals, a piecemeal system that despite all its flaws does provide care for anyone in the United States experiencing an emergency medical condition.

A second normative source of the societal obligation to have a functioning acute care infrastructure is a basic moral principle: the

duty to provide aid to people in distress (or the duty to rescue). This principle asserts that, if one is in a position to rescue someone from substantial harm at minimal risk or cost to oneself, one is morally obligated to do so.[10] Although different ethical systems ground this principle in different ways, it is a widely agreed upon moral obligation. Even among political philosophies that reject health care as a universal right, there appears to be consensus that persons are entitled to treatment of emergent threats to their well-being using societal resources, an entitlement entrenched in US law through EMTALA for three decades. In effect, it is the duty to rescue applied to all society: a proportionally small cost is borne by society to provide resources to rescue any of society's members.

These principles provide substantial support for a societal obligation to provide resources to maintain an acute care infrastructure. However, how should societies fulfill this obligation? In societies with national health systems or more centralized emergency services, there is a straightforward answer: citizens transfer the obligation to provide resources for emergency care to a governmental health service or single-payer insurance, and the governmental health service or single insurer must maintain the acute care infrastructure. In the United States, with its fragmented EMS system, multiple and complex networks of health care funding arrangements, combination of private and safety-net hospitals, and the unfunded mandate of EMTALA, the strands of obligation are obscured. The fragmented healthcare delivery and funding arrangements in the United States do not, however, change the moral significance of the obligation to maintain a robust acute care infrastructure. Public and private health insurance providers collect funds from taxpayers and enrollees in order to provide health care, including emergency care, for patients in need. It is therefore these insurers who should bear the social obligation to maintain the acute care infrastructure. This obligation should include providing fair coverage for their beneficiaries and being transparent about how payments are calculated; otherwise, insurance companies might exploit EMTALA to reduce coverage for emergency care, knowing the federal mandate for EDs to provide emergency services for all patients, regardless of ability to pay, will still be enforced.[11] Because reliance on retrospective analysis of clinical or claims data is fraught with inaccuracy, this method of determining financial responsibility may not provide adequate support for emergency care.[12]

4 | PATIENT OBLIGATIONS

Some patients choose to seek primary care services in an ED, although the ED might not be the ideal site of care for those services. While there is little debate about whether care should be provided for emergencies as described under EMTALA, provision of primary care services in the ED has been more controversial. Arguably, patients who choose unscheduled, episodic care in an ED should bear some financial responsibility for that choice. Conversely, it can be argued that patients are frequently referred to the ED by primary physician offices for urgent and emergent evaluation, especially when patients call their primary physician outside of regular business hours. Patients may have few other options to access care besides the ED, even if they have insurance, because of problems with care availability (match of clinicians to patient demand), accessibility (ability for patient to reach care location), accommodation (whether care is organized in ways that meet patient needs, such as hours of operation and appointment scheduling), and acceptability (match between patient attitudes and expectations and the care available to them).[13] Studies have repeatedly shown that these non-financial barriers to care remain substantial even for insured patients, and that they drive ED utilization.[14-17]

A more worrisome issue than individuals using EDs for access to primary/non-urgent care is the expectation that patients who present to the ED with concerning symptoms such as chest pain, abdominal pain, or shortness of breath should determine what is or is not an emergency. A recent study suggested that only 3.3% of all ED visits in the United States are "avoidable," based on a strict definition of when ED care is appropriate.[18] These results are similar to CDC data that 96% of patients presenting to the ED require care within 2 hours.[19] Requiring the patient to bear significant financial cost associated with ED evaluation and treatment could have the negative effect of discouraging patients from seeking necessary evaluation and treatment. In one study, 30% of patients would not seek ED evaluation if it required that they make a co-payment for services, including more than 1 in 5 patients with chest pain, shortness of breath, and abdominal pain.[20] Additionally, in a 2016 poll, 8 in 10 emergency physicians reported that they had treated patients who had delayed care due to high deductible health plans and other out-of-pocket costs.[21]

5 | CURRENT APPROACHES AND FUTURE PROSPECTS

A longstanding practice of many US hospitals has been to write off most of the cost of care for patients without insurance as bad debt or charity care.[22] The Patient Protection and Affordable Care Act (ACA) of 2010[23] increased insurance coverage for millions of Americans, although the ACA has remained politically controversial, with multiple court challenges and efforts to change or repeal the law. Among the consequences of the ACA is broader insurance coverage in the US population, but with many individuals enrolled in high deductible health plans. Defining the appropriate use of emergency care is central to discussing patient responsibilities in an environment with emerging, novel payment models. Developments such as high deductible health plans bring the concept of patient responsibility to the forefront of the discussion of necessary funding for sustaining a robust acute care system. The prudent layperson concept has provided a standard, although in an environment of changing reimbursement and funding, there are financial incentives for insurers to redefine that standard and to be nontransparent about network coverage. That is, many insurers have not contracted with emergency physicians to ensure payment at in-network rates.[24–26] To address this issue, a group of professional organizations representing hospital-based physician specialties released the *Consensus Principles on Insurance Coverage for*

Out-of-Network Care Provided by Hospital-Based Physicians, affirming that "When insured patients are treated in the hospital, they should be confident in the knowledge that their health insurance will cover them."[27]

These issues suggest the importance of transparency on the part of all parties, and not simply at the time of an ED visit. Insurers either should inform patients that some emergency services or portions of an ED visit are not covered (even though that could disincentivize a patient from seeking care), or, in a more patient-centered approach, should negotiate in-network payment agreements with emergency physicians.

Evolving reimbursement models such as the Medicare and CHIP Reauthorization Act of 2015 (MACRA) are changing Medicare reimbursement to physicians. MACRA includes new reporting systems including Alternative Payment Models and Merit Based Incentive Payment System (MIPS). Although a detailed discussion of Alternative Payment Models is beyond the scope of this paper, these evolving reimbursement models will affect care for individual ED patients in the context of population health management. In the current era of payment reform, it is also essential to focus on the nuances of emergency medical care that pose challenges and opportunities for delivery reform.[28]

6 | CONCLUSIONS

The dynamic environment of payment and reimbursement reform makes ethical discussions about ensuring access to a robust, high-quality acute care infrastructure vitally important. To enable patients to make informed choices, they should be informed by their insurers and their care providers about the costs of the ED care they seek, both at the time care is provided and, where feasible, in advance. Depending on the terms of an insurance plan, patients might be held responsible for sharing some of the costs associated with ED care. Emergency physicians have an ethical as well as a legal obligation to evaluate and stabilize patients with life and bodily function threatening conditions, regardless of the payment system in which emergency care is provided. In the current US health care system, governments, health systems, and health insurers should recognize a shared social responsibility to enable emergency physicians to carry out this obligation.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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How to cite this article: Kraus CK, Moskop JC, Marshall KD, Bookman K. Ethical issues in access to and delivery of emergency department care in an era of changing reimbursement and novel payment models. *JACEP Open*. 2020;1–5. https://doi.org/10.1002/emp2.12067