

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - A-03  
(June 2003)

Subject: Payment for Emergency Services

Presented by: Cyril "Kim" Hetsko, MD, Chair

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1 At the 2002 Annual Meeting, the House of Delegates adopted Substitute Resolution 204. The  
2 resolution calls on the AMA to investigate and explore creative sources and options for new,  
3 expanded, and non-traditional sources of funding necessary to support the day-to-day delivery and  
4 all emergency health services. In addition, the resolution asks that such emergency health services  
5 be defined to mean the full spectrum of access and capacity, including but not limited to: primary  
6 and specialty care access, on-call services, intensive care capacity, EMTALA related requirements,  
7 trauma care, and bioterrorism preparedness. The Board of Trustees assigned the requested study to  
8 the Council on Medical Service for a report back to the House of Delegates at the 2003 Annual  
9 Meeting.

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11 The following report, which is presented for the information of the House, summarizes the current  
12 environment facing emergency rooms and trauma care; outlines several options that have been  
13 proposed to raise funds for such care; discusses the specific recent efforts of two states to raise  
14 money for emergency services; and reviews AMA policy.

### 15 BACKGROUND

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18 Over the past three years, both the Council on Medical Service and the Board of Trustees have  
19 presented a series of detailed reports to the House on a variety of issues related to emergency  
20 services. These include:

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- 22 • Overcrowding and Hospital EMS Diversion, Council on Medical Service Report 1  
23 (A-02)
  - 24 • The Effects of Closing Safety-Net Hospitals, Council on Medical Service Report 3 (I-01)
  - 25 • The Growing Nursing Shortage in the United States, Council on Medical Service Report 7  
26 (A-01)
  - 27 • On-Call Physicians Task Force, Board of Trustees Report 29 (A-00)
  - 28 • On-Call Physicians, Council on Medical Service Report 3 (I-99)
- 29

30 It has long been recognized that the numerous problems in America's emergency departments is a  
31 warning sign that the nation's hospital systems are systematically failing. Most experts agree that  
32 the problem is not with the emergency departments themselves, but with the ability of the rest of  
33 the health care system to handle patient demands and needs. Emergency room visits nationwide  
34 continue to rise at a rate of about one million visits per year. With the steady rise in the number of  
35 patients visiting emergency departments over the last decade, coupled with the progressive decline  
36 in the number of emergency departments, serious problems have developed.

1 The Council noted in its recent report on overcrowding and diversion (Council on Medical Service  
2 Report 1, A-02) that there are many factors that contribute to the problems with emergency  
3 services. Key among these factors are the following:  
4

- 5 • The rise in professional liability insurance premiums, examined in Council on Medical Service  
6 Report 12 (A-02), which is causing some physicians to move, retire early, or cease practicing  
7 high-risk specialties, such as emergency medicine.  
8
- 9 • The steady and constant rise in the number of emergency room visits, due to both an aging  
10 population and the increasing number of uninsured patients. The percentage of emergency  
11 patients who are indigent or uninsured rose between 1992 and 1999 from 13.8% to 16.2%. The  
12 majority of doctors (71%) responding to a recent American College of Emergency Physician  
13 survey reported that uninsured patients seen in the emergency room tended to be sicker and  
14 have more serious medical conditions than patients with health coverage.  
15
- 16 • The growing nursing shortage, an issue still cited by nearly every hospital, which was  
17 examined in detail by Council on Medical Service Report 7 (A-01). Government projections  
18 indicate that by 2015, 114,000 full-time equivalent nursing positions will be unfilled  
19 nationally.  
20
- 21 • A national shortage of hospital beds. High occupancy rates often leave no room for emergency  
22 arrivals, forcing patients to be “parked” in hallways, sometimes for days. A 2001 industry  
23 survey of 715 hospitals found that nearly half were running at 90% occupancy during peak  
24 periods, drastically higher than a decade ago.  
25
- 26 • Hospital and emergency department downsizing, closures, mergers, and/or restructuring, an  
27 issue addressed in the Council’s report on the closing of safety-net hospitals. The *Los Angeles*  
28 *Times* reported that 50 emergency departments closed in California between 1990 and 1999,  
29 while, in Arizona, 6% of hospitals have closed since 1998.  
30
- 31 • Low payment rates for hospitals and physicians, from both the public and private sector for  
32 emergency services. The Emergency Medical Treatment and Active Labor Act (EMTALA)  
33 has contributed to a decline in physicians’ willingness to provide services because many of  
34 these services will be uncompensated. According to the AMA’s 2001 Patient Care Physician  
35 Survey (PCPS), more than 30% of physicians provide care covered by EMTALA in a typical  
36 week of practice. Emergency medicine physicians average 22.9 hours of EMTALA mandated  
37 care per week, about half of their total patient care hours. Emergency medicine physicians  
38 attribute 61% of the bad debt they incurred in 2000 to EMTALA, or \$138,300 per year.  
39
- 40 • The growing number of specialists who refuse on-call coverage, a topic examined in detail by  
41 both the Council and the Board. Some hospitals have resorted to paying key specialists as  
42 much as \$2,000 a day for emergency room coverage. One California hospital is even  
43 reportedly spending \$5 million a year on emergency department call. In 2002, several trauma  
44 centers across the country closed for periods ranging from two to four months due to an  
45 insufficient number of on-call physicians. These centers reopened only after the hospital  
46 agreed to compensate physicians for on-call coverage.

- 1 • The continued erosion of emergency response systems, which has taken on a different  
2 emphasis since September 11, 2001.

3  
4 In March 2003, the General Accounting Office (GAO) released a report entitled “Hospital  
5 Emergency Departments: Crowded Conditions Vary among Hospitals and Communities.” The  
6 GAO was asked to provide information on emergency department crowding, including the extent  
7 hospitals located in metropolitan areas are experiencing crowding, and the actions hospitals and  
8 communities have taken to address crowding. As a means of gathering such information, the GAO  
9 surveyed over 2,000 hospitals and approximately 74% responded. The GAO found that the factor  
10 most commonly attributed to crowding was the inability to transfer patients to inpatient beds once a  
11 decision had been made to admit them as hospital patients. The GAO also concluded, similar to  
12 Council Report 1 (A-02), that no one approach to the crowding issue was likely to emerge as a way  
13 to address this ongoing concern.

14  
15 Emergency departments rely on a variety of funding sources. However, to finance the significant  
16 portion of uncompensated care, many hospitals rely on local or state government subsidies,  
17 Medicaid and Medicare disproportionate share hospital (DSH) payments, cost shifting, and other  
18 programs. As a result, some hospitals have been placed in a precarious financial position as they  
19 have become uniquely reliant on governmental sources of financing, many of which have been  
20 substantially reduced since 1997.

#### 21 22 PROPOSALS TO FUND EMERGENCY CARE

23  
24 Over the years, there have been a number of progressive proposals from a variety of sources on  
25 how to increase funding for emergency health care. Some of the proposals listed below have been  
26 supported by the Council in its previous reports to the House. Some of these proposals are being  
27 currently implemented, or have been attempted, while others are in the planning stage. These  
28 proposals are considered by some to be creative alternatives that may or may not be successful.  
29 There are pros and cons to each of these proposals that need to be weighed carefully on a case-by-  
30 case basis. It is also possible that in order to raise adequate funds for delivery of emergency  
31 services, a combination of several different proposals may be necessary. Among the more recent  
32 proposals are the following:

- 33  
34 • Seek legislative relief to obtain funding for the provision of emergency services from the  
35 federal budgets of the Bureau of Alcohol, Tobacco & Firearms, and the Department of  
36 Transportation.
- 37  
38 • Seek legislative relief from the federal budget to get the “EMTALA mandate” funded outside  
39 of budget neutrality. Although EMTALA is a directive from the federal government, it  
40 contains no provisions to fund services provided by emergency physicians or on-call  
41 specialists, and therefore is an unfunded mandate. Many feel it is the federal government’s  
42 responsibility to provide reimbursement for all services provided under EMTALA’s mandate.
- 43  
44 • Seek funds from the newly created Department of Homeland Security for upgraded services  
45 and facilities, as well as appropriate training of emergency health workers. While \$31 billion  
46 has been earmarked for emergency defense and anti-terror funding, many feel some of this

1 money would be better focused if used “offensively” to upgrade technologies and better  
2 prepare emergency response systems, as opposed to waiting for a disaster to strike.

- 3
- 4 • Support federal and state actions that raise revenues from settlement initiatives and so-called  
5 “sin taxes” on tobacco, alcohol, handguns, assault weapons, and ammunition.
- 6
- 7 • Support sale of personalized or specialty license plates to raise money for trauma care, or  
8 collect a surcharge on motor vehicle registrations.
- 9
- 10 • Support more focused efforts to obtain more city/community service funds for emergency  
11 funds and disaster relief, possibly by imposing local taxes through a referendum.
- 12
- 13 • Enhance funding for the recruitment and retention of qualified individuals to the nursing  
14 profession and the allied health fields.
- 15
- 16 • Continue to support legislation that would require health plans to compensate out-of-plan  
17 physicians for emergency services provided to the health plans’ enrollees.
- 18
- 19 • Support federal legislation that would extend Medicaid Disproportionate Share Hospital (DSH)  
20 payments. These subsidies need to follow the patient (for the benefit of both the patient and  
21 the physician).
- 22
- 23 • Require health plans to share in the expense of trauma care, perhaps by implementing a state  
24 tax on health plan profits.
- 25
- 26 • Encourage the development of statewide ballot initiative processes, such as those in California.

#### 27 28 RECENT STATE EFFORTS AND LEGISLATIVE PROPOSALS

29  
30 In recent months, numerous states have tried to tackle their own emergency care funding  
31 predicaments. A draft bill in Florida calling for the creation of a special tax district was passed in  
32 early 2003 by Lee Memorial Health System’s Board of Directors. The proposed bill would make  
33 trauma services at Lee Memorial a special district, and subsequently allow the hospital to seek  
34 property taxes from residents through an election referendum. Any money raised would go only  
35 for trauma services.

36  
37 The bill is the second of two attempts to raise ongoing money to pay for Southwest Florida’s only  
38 trauma center and the physician specialists who care for nonpaying trauma patients. The first idea,  
39 a half-cent sales tax, was voted down in November 2002 by a margin of 57% to 43%. Many voters  
40 indicated that they did not want to pay \$35 million toward an array of emergency and indigent-care  
41 services the tax initiative required.

42  
43 The newest property tax proposal would raise roughly \$11 million a year. In the bill, the Lee  
44 Memorial Board approved a sunset clause of five years for any approved tax and put a tax limit of  
45 three-tenths of a million in the wording. That means if voters approve, a property owner would pay  
46 about \$30 for every \$100,000 of taxable property. Even if voters reject another tax attempt,  
47 hospital officials say having a tax district would be beneficial anyway, if only to highlight trauma

1 operations and funding separately from the hospital. The bill calls for the district to have its own  
2 budget and its own governing board, which would consist of the same elected officials who now  
3 direct the health system. A special district also would allow money donors to easily earmark their  
4 gifts specifically for the trauma center.

5  
6 Similarly, the chairman of a study panel told Maryland state legislators in February 2003 that the  
7 state needs to allocate \$15 million a year (out of a \$22-billion budget) to the trauma system in order  
8 to avoid a shutdown such as the one that closed the center at Washington County Hospital for four  
9 months in the summer of 2002. A group of trauma surgeons and hospital administrators agree that  
10 help is needed to avoid shutdowns at any of the state's nine trauma centers.

11  
12 The Vice President for Medical Affairs at Peninsula Regional Medical Center in Maryland said  
13 that, without extra aid, his hospital might have to shut its trauma service in July 2003, when a new  
14 contract with its trauma surgeons is expected to mean higher costs. Already, the medical center is  
15 facing about \$1 million a year in costs to pay physicians to be on stand-by and to cover care for the  
16 uninsured. Furthermore, Dimensions Healthcare System in Maryland is "seriously considering  
17 eliminating the trauma program" at Prince George's Hospital Center, one of two hospitals it owns.  
18 Of the 2,500 trauma patients at Prince George's each year, 35% are uninsured, and the hospital  
19 pays \$11 million a year for physicians to provide coverage.

20  
21 Maryland already collects \$49.6 million a year from an \$11 surcharge on motor vehicle  
22 registrations to support the trauma system. Lawmakers considered increases in alcohol taxes, more  
23 mandates on auto insurance, and surcharges on driver registration fees as possible ways to raise  
24 money. Among the draft recommendations of the study panel were a state fund to pay physicians  
25 for uncompensated care and/or being on-call, an increase in Medicaid payments for trauma care,  
26 and legislation forcing health maintenance organizations (HMOs) and other private insurers to pay  
27 higher rates for trauma care.

28  
29 In March 2003, a half-cent per dollar local increase in the state's sales tax within Detroit and  
30 Wayne County, Michigan, was proposed to pay for indigent and trauma care. The idea, which is in  
31 early stages of discussion, is one of several proposals officials at Detroit Medical Center (DMC)  
32 are advocating to help offset mounting losses at the DMC, the area's largest health system. With  
33 \$80 million in losses in 2002, the fifth consecutive year of losses, DMC has cut programs, reduced  
34 staff from 21,000 to 14,000, and frozen pay for directors. At the time this report was written,  
35 possible repercussions of closing some of DMC's facilities were being examined. Closing any of  
36 the three DMC hospitals would have an immediate impact on the nearby Henry Ford and St. John  
37 Health systems.

38  
39 The Senate Health, Education, Labor and Pensions Committee passed legislation in February 2003  
40 reauthorizing the Trauma Care Systems Planning and Development Act, which expired last year.  
41 The new bill would help state budgets by dropping the requirement that states match federal grants  
42 with their own funds. It also would authorize twice as much funding as the old legislation to allow  
43 more states to participate. Currently, only half of the states have a statewide trauma center system.

#### 44 AMA POLICY

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47 The AMA has extensive and long-standing policies that address issues related to emergency  
48 services (Policies H-130.950, H-130.954, H-130.957, H-130.960, H-130.961, H-130.965,

1 H-130.968, H-130.970, H-130.978, H-130.982, H-130.989, H-130.975, H-130.964, H-285.954,  
2 H-215.976, H-240.963, H-240.964, H-240.968, H-360.991, H-360.993, H-360.995, H-360.999,  
3 H-360.986, AMA Policy Database). Policy H-130.970(2), which was developed by the Council,  
4 supports the principle that all physicians and health care facilities have an ethical obligation and  
5 moral responsibility to provide needed emergency services to all patients, regardless of their ability  
6 to pay. Policy H-130.970(5) states that all health plans should be required to cover emergency  
7 services provided by physicians and hospitals to plan enrollees. Policy H-240.964 states that the  
8 AMA recognizes the special mission of public hospitals and supports federal financial assistance  
9 for such hospitals; and advocates that studies be carried out to evaluate whether special  
10 consideration for public hospitals is justified in the form of national or state financial assistance,  
11 and if so, it should be implemented. Lastly, Policy H-240.963, also developed by the Council,  
12 states that Medicare and Medicaid subsidies and contracts related to the care of economically  
13 disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to  
14 this population in order to prevent the loss of services provided by these facilities.

15

## 16 CONCLUSION

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18 The Council on Medical Service recognizes that, since the events of September 11, 2001, health  
19 care organizations are being forced to rethink their emergency response systems and confront the  
20 adequacy of emergency services in the U.S. Hospital trauma care and emergency services have  
21 become even more imperative as the nation prepares for the impact of possible future catastrophic  
22 events. The Council continues to believe that many of the problems related to funding for  
23 emergency services are systemic, and are due to a lack of surge capability and lack of elasticity in  
24 the marketplace.

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26 The Council is encouraged, however, by the increasing number of creative solutions to emergency  
27 funding problems that have been proposed, and encourages states and local communities to  
28 continue to explore various alternatives. The Council continues to believe that methods of  
29 compensation for physicians who treat the uninsured must be further improved, as well as efforts to  
30 increase health insurance coverage to the uninsured.

31

32 At the root of these problems is the large number of uninsured patients arriving daily in emergency  
33 rooms across the nation. Long-standing AMA policies advocating to decrease the number of  
34 uninsured through incremental steps such as refundable tax credits, enhanced enrollment outreach  
35 to Medicaid/State Children's Health Insurance Programs (S-CHIP) populations, and increasing  
36 payments to hospitals and physicians for emergency services from both federal and private payers,  
37 are the primary solutions for the majority of emergency funding problems. Nonetheless, the  
38 Council continues to believe that, due to the variety of differing state and federal proposals, there is  
39 little merit in supporting only one solution that would universally apply to every situation in every  
40 community.