Positive and Negative Implications of EMTALA

Consumer

According to author Italow Brown (2013), one of the primary links to death in the United States are chronic conditions. Today's medical care aims to address these issues through preventative measures and disease management (Brown, 2013). Approximately 325 million people are living in America of which approximately 40 million individuals are without health care coverage, that is approximately 12.2% of the nation (Luhby, 2018). Of the uninsured individuals, 31.3% of them live with chronic conditions such as cardiovascular disease, hypertension, diabetes, or various forms of cancer (Gever, 2008). These individuals look to other methods when their chronic illnesses need medical attention. One way they are able to obtain care is through a method that our government has instilled into our medical system known as the Emergency Medical Treatment and Active Labor Act (EMTALA).

EMTALA is a governmental policy that allows uninsured individuals to check into any Medicare backed emergency room regardless of race, religion, financial situation, or citizenship (Zibulewsky, 2001). The Act then states that these individuals must be given a medical screening and stabilized before their release, transfer, or admittance (Zibulewsky, 2001). EMTALA was put in place by our government to decrease "patient dumping," which is the act of transferring patients with the inability to pay for services. So, as you can see, EMTALA is a wonderful system that helps provide access for the uninsured when they need medical attention, but it does come at a price to others.

Provider

Emergency room providers are some of those individuals who are being hamstrung by policies such as EMTALA. On average, there are approximately 120 million emergency room

visits in the United States per year (Gardner, 2010). Research shows that most injuries and chronic illnesses take place after normal business hours, leaving the emergency rooms as a final resort for many people no matter their insurance status. This higher influx of patients can create many issues for the already short-staffed or on-call emergency room providers. The physicians must take the time to give a proper medical screening to all individuals covered under EMTALA. This action not only uses up the provider's time, but it can also be a waste or utilization of department resources that could have gotten used on a patient where the ER would get reimbursed.

Emergency room physicians are unfortunately at a large disadvantage when it comes to getting paid for their services. By law, they must care for everyone no matter their insurance status or ability to pay and then beg for payment later (Riner, 2012). Other types of healthcare providers, such as general and family practice, have the luxury of being able to screen their patients to ensure payment or even elect not to care for certain individuals due to their insurance plan. Others are also able to create ongoing relationships with their patients and negotiate payment plans through prior authorization for services (Riner, 2012). The downside to these providers picking and choosing who they want to see is causing more issues than they know.

According to the Association of American Medical Colleges of the United States, we will have a physician shortage of approximately 160,000 by 2025 (Siegel, 2010). This fact, along with the ever-increasing Medicaid population, is causing general physicians to limit who they see, leaving the chronically ill with only one place to go, the emergency room. However, we have also seen a drastic increase in emergency room closures since 1991 due to financial burdening from uncompensated care under EMTALA (Siegel, 2010). So, as you can see, the numbers do not add up in favor of the facilities or the providers. EMTALA is going to continue

to cause financial and staffing difficulties for our ERs unless much-needed attention is given to the Act, changing our course of action.

Insurer and Reimbursement

Third-party payers are aware of the burden and constraints that gets put on US emergency rooms due to laws such as EMTALA, and they use a variety of ways to control monetary reimbursement to those providers for their emergency care services (Riner, 2012). One example of this is known as the denial of coverage, and this happens because of systems like the Balanced Budget Act of 1997. This Act puts strict controls and definitions on reimbursement for emergency care by limiting the words "emergency diagnosis" (Riner, 2012).

Third-party payers often find loopholes through Acts such as this and refused to pay because the final diagnosis does not match the criteria needed to get deemed emergent (Riner, 2012). Another method insurance companies use to take advantage of EMTALA is known as down-coding. They are essentially down coding the emergency providers claim before paying out any benefits. They take it upon themselves to determine the level of seriousness and override the physician's views of the situation (Riner, 2012).

Bundling is another system used by large commercial plans. They inappropriately combine the services that were provided by the physician to decrease the money that is paid out for that claim. Delayed payments and coercive contracting are other methods of tweaking the system. By delaying payments, the third-party payers will make money on the float and give the illusion that they are staying within the timely guidelines set by the system. Coercive contracting involves accepting extremely discounted below market rates for plans (Riner, 2012). Another method they use is known as threatening to divert payment. This action is where the insurers will threaten to send payments to the patients instead of the emergency physician unless the

provider agrees to accept a discounted rate. They do this knowing full well that it is more difficult for the provider to get the funds from the patient than it is to get them from the insurance company (Riner, 2012). Several other methods ER physicians might encounter would be the renting of providers to other networks, recoupment, receiving payments at a triage rate, or payment adjustments to name a few (Riner, 2012).

According to the American College of Emergency Physicians (ACEP) (2018), in 1998, the Lewin Group study for CMS defined the term charity care. EMTALA often falls under this category and may also be known as charity care, uninsured care, uncompensated care, indigent care, or bad debt (ACEP, 2018). The United States performs more charity care than any other established nation throughout the world. According to the study, charity care is defined as a non-reimbursement of care by an emergency physician with the included definition of bad debt (ACEP, 2018).

In 2000, our nation's ERs reported that 61% of their charity care, or bad debt, was directly related to the mandated EMTALA (ACEP, 2018). Of that 61%, 27.7% of the ER physicians reported EMTALA as their only area of bad debt (ACEP, 2018). Hospitals and other healthcare organizations are continually struggling to find other methods to write off their ever-increasing bad debt related to policies such as EMTALA. There must be adjustments made, or we will continue to see closure after closure as these organizations will no longer be able to afford "free care."

Service Delivery along with Performance and Quality

Although there seems to be a lot of negative aspects for the ER provider, one of the pros that we could mention is that it does bring business into the facilities. EMTALA has increased service delivery immensely, allowing the uninsured a place to obtain care in our emergency

rooms. According to the American Heart Association, ER visits have increased at an unfathomable rate. From EMTALA's inception in 1986, we have seen ER visits increase from 77 million to 127 million as of 2009 (Friedman, 2001). There is no doubt that the policy has increased methods of availability to the population, but does it come at a price regarding performance and quality? The Act has created the enormous issue of ER crowding, and with this high influx of patients, we are starting to see the effects take their toll on the staff.

Do the providers utilize the same amount of care for EMTALA patients as they do for the insured? One would like to think so, but it is often not the case. Due to the shortage of physicians and lack of staff within the ERs to handle the larger volume of patients we are still seeing patient dumping and rapid and inadequate care (Friedman, 2001). Organizations are pushing their providers to move out the charity cases as fast as possible in hopes that many of the cases fall by the wayside (Friedman, 2001). These actions help to increase the time needed for the physicians and staff to work on the individuals that will gain reimbursement for the organization and will decrease the overall losses sustained by the uninsured (Friedman, 2001).

Conclusion

So, is EMTALA a great system, and how many individuals has it saved? The answer is simple, who knows to put it bluntly, and it would be almost impossible to determine precise data. But, it has increased access for those who normally would not have the ability to obtain care, and it does provide a justifiable service when used correctly. But at some point, we must consider the numerical facts and realize that we may not be able to maintain the system in the way that it currently gets used. Eventually, the parties that be must take a long hard look at the situation if we are ever to find a balance between access and reimbursement.

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