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The Impact of EMTALA on Physician Practices

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The Emergency Medical Treatment and Labor Act (EMTALA), included in the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, was passed by Congress in response to reports of "patient dumping." EMTALA was intended to prevent hospitals from refusing to treat patients or from transferring patients based on their ability to pay, thereby ensuring timely access to emergency medical care regardless of that ability or of patients' insured status.

EMTALA requires hospital emergency departments (ED) to screen patients presenting at the ED to determine if an emergency medical condition is present. If an emergency medical condition is found, EDs are required to either stabilize the patient prior to transfer, or to obtain a certification that the transfer is appropriate. Although providers are required to screen and stabilize patients, insurer payment for that treatment is not guaranteed. Payment for services covered under the scope of EMTALA may also not be forthcoming because of patients' abilities to pay. For these and other reasons, hospitals and physicians report that compliance with ETMALA has had adverse financial effects.

This report describes the number of hours that physicians spend providing care that is mandated by EMTALA. It also provides preliminary estimates of EMTALA's financial impact on physicians. The data in this report are from the American Medical Association's 2001 Patient Care Physician Survey (PCPS). The PCPS is a nationally representative survey of post-residency, non-federal, patient care physicians that is conducted via mail and phone interviews. Physicians surveyed in the PCPS were asked how many hours they spent providing EMTALA mandated care in a typical week of practice and asked for the percent of their 2000 bad debt that was associated with such care.

TIME SPENT PROVIDING EMTALA MANDATED CARE

Although 95.2% of emergency medicine physicians provided at least some EMTALA mandated care in a typical practice week (Table 1), there was substantial variation among those physicians in terms of how many hours they provided. Thirty-eight percent provided between one and 10 hours per week, 12.9% between 11 and 20 hours per week, 12.9% between 21 and 30 hours per week, 19.8% between

31 and 40 hours per week, and 16.4% provided more than 40 hours of EMTALA mandated care per week (Table 2).

Physicians with a specialty in emergency medicine reported the greatest number of hours of EMTALA mandated care, 22.9 per week (Table 1). Although physicians in other specialties also provided services covered by EMTALA, the hours they spent providing such care amounted to fewer than 6.0 per week. After emergency medicine physicians, EMTALA mandated care was provided most often by general surgeons, internal medicine subspecialists, and radiologists who spent 5.7, 3.7, and 3.6 hours per week, respectively, in that aspect of patient care. General surgery was the only specialty other than emergency medicine in which more than 50.0% of physicians reported that they provided any EMTALA mandated care in the course of a typical week of practice. Among general surgeons who provided such care the average number of hours spent doing so was 9.4 hours per week.

The amount of time that physicians spent providing EMTALA mandated care depended on the area of the United States they practiced in. Physicians in the West North Central census division were the least likely to have provided any EMTALA mandated care, only 25.3% in a typical week did. At the other extreme was the West South Central census division where 40.3% of physicians did. The average number of hours per week ranged from 1.8 in the Middle Atlantic census division to 3.9 in the East South Central census division (Table 1).

Regional variation in the provision of EMTALA mandated care may be related to the variation in the number of uninsured. Uninsured persons are more likely than the insured to rely on the ED as a usual source of care[1]. Although the ED care that such patients receive may not ultimately be of an emergent nature, screening exams must still be provided. The delay of primary and preventative care because of inadequate access to care (which is not limited to only uninsured persons[2]) may result in the escalation of symptoms to an emergency level and contribute to EMTALA mandated care in this way.

FINANCIAL IMPACT OF EMTALA MANDATED CARE

We measure the financial impact of EMTALA on physicians' practices by the amount of bad debt incurred from the provision of EMTALA mandated care. Bad debt is associated with the provision of services for which payment was expected but not received. It is not associated with the provision of charity care for which either no payment is expected, or only payment at a reduced rate. Moreover, bad debt is not associated with the provision of services for which a reduced fee has been negotiated with an insurer. For example, the difference between a physician's usual charge for a certain service and the fee that a Medicaid HMO pays does not amount to bad debt. If, however, a Medicaid HMO patient was obligated to make a copayment and did not, that portion of the bill would be considered bad debt; that payment was expected but not received. Bad debt related to EMTALA could result from patient non-payment of amounts not covered by insurance, insurer denial of payment, and insurer downcoding of claims. A recent article found that claims were often downcoded or denied even in cases when preauthorization for services provided in the ED had been obtained[3].

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[1] Dubay, Lisa and Genevieve M. Kenney. "Health Care Access And Use Among Low-Income Children: Who Fares Best?" *Health Affairs* 20 (January/February 2001): 112-121.

[2] Berk, Marc L. and Claudia L. Schur. "Measuring Access to Care: Improving Information for Policymakers." *Health Affairs* 17 (January/February 1998): 180-186.

[3] Young, Gary P. et al. "Managed Care Gatekeeping, Emergency Medicine Coding, and Insurance Reimbursement Outcomes for 980 Emergency Department Visits From Four States Nationwide*." Annals of Emergency Medicine* 39 (January 2002): 24-30.

In the 2001 PCPS, physicians were asked for the total dollar value of bad debt they incurred in 2000 and the percentage of bad debt that was attributable to EMTALA. The annual dollar value of bad debt from EMTALA for each physician was constructed by multiplying the first measure by the second.

Forty-two percent of self-employed physicians incurred some bad debt from EMTALA in 2000 (Table 3)[4]. The average share of bad debt attributable to EMTALA was 13.7%, or $12,300. In the aggregate this amounts to nearly $4.2 billion dollars. Not surprisingly, these figures were largest among emergency medicine physicians, all of whom reported at least some bad debt associated with EMTALA in 2000, with an average of 61.0% of bad debt attributed to that source, or $138,300. For 27.7% of emergency medicine physicians, EMTALA was the only source of bad debt (not shown in Table 3). The impact of EMTALA on the financial outcomes of other physicians was much smaller but, in certain specialties, non-trivial.

More than 60.0% of internal medicine physicians, general surgeons, and anesthesiologists indicated that EMTALA was responsible for at least some of their 2000 bad debt. In each of those specialties EMTALA accounted for more than 20.0% of bad debt, amounting to $26,900, $25,600, and $16,500 per year, respectively. Although fewer than 50.0% of radiologists incurred any bad debt from this source and the average percentage attributable to EMTALA was less than 20.0%, physicians in that specialty still incurred $22,000 worth of EMTALA related bad debt.

Fewer than 25.0% of pediatricians, psychiatrists, pathologists, and physicians in 'other specialties' incurred any bad debt from EMTALA in 2000 and their average share from that source was less than 5.0%. This amounted to between $1,200 worth of bad debt for psychiatrists to $4,500 for physicians in other specialties.

The financial impact of EMTALA on physicians' practices also varied geographically. Nearly twice as many physicians in the East South Central census division than in New England attributed at least some bad debt to EMTALA, 59.3% compared to 31.6%. The average share of bad debt from EMTALA was nearly three times as large, 21.3% compared to 7.4%, and the level of bad debt from that source more than seven times as large, $28,600 compared to $3,800, respectively.

The financial impact of EMTALA varies geographically for a variety of reasons. First, as we saw earlier, the provision of EMTALA varied geographically. Also, whether physicians (and hospitals) are reimbursed for that care depends on the insured status of the patient population as well as insurer practices regarding the medical claim process. Finally, the resource cost of providing ED services, which also is area specific, plays a role in determining how large the financial impact of EMTALA on physicians will be.

CONCLUSION

In 2001, more than 30.0% of physicians provided care covered by EMTALA in a typical week of practice. Among some specialists this percentage was much higher, 60.9% among general surgeons and 95.2% among emergency medicine physicians. Emergency medicine physicians averaged 22.9 hours of EMTALA mandated care per week, about half of their total patient care hours, and 16.4% of those who provided such care averaged more than 40 hours per week.

[4] In the PCPS, a physician is only asked about her share of her practice's bad debt, and subsequently about bad debt from EMTALA, if she is a full or part owner of her practice (self-employed).

Emergency medicine physicians attributed 61.0% of the bad debt they incurred in 2000 to EMTALA, or $138,300 per year. Across all specialties EMTALA related bad debt amounted to $12,300 per self-employed physician in 2000, or nearly $4.2 billion dollars in the aggregate.

The $4.2 billion estimate likely overstates of the impact of EMTALA on physician net income. First, looking only at the level of bad debt ignores that EMTALA may have had, in part, a positive revenue impact on physicians. If patient volume is greater under EMTALA than it would have been in its absence, to the extent that physicians are able to collect payment for services covered under the scope of EMTALA, revenue from screening and stabilization will be greater than it otherwise would have been. Second, some of the bad debt attributable to EMTALA would have been incurred even in the absence of this legislation—providing screening and stabilization is, after all, the business of hospital EDs.

The net impact of EMTALA on physician income depends on the magnitude of the increase in patient volume from EMTALA, how often and by how much insurers deny and downcode claims for EMTALA care, the extent of patient non-payment of amounts not covered by insurance, and the difference between revenues generated from emergency care and the cost of providing it. While PCPS data can't address each of those components, the data clearly show that a substantial amount of care covered by EMTALA goes uncompensated, suggesting that EMTALA has had an adverse financial impact on physician income.

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Table 1. Physician Provision of EMTALA Mandated Care, 2001

	Percent of Physicians Providing EMTALA Mandated Care [a]	Weekly Hours of EMTALA Mandated Care [b c]	Weekly Hours of EMTALA Mandated Care Among Physicians Who Provide Care [b]
All Physicians	31.4%	2.7	8.7
SPECIALTY			
General/Family Practice	23.8	1.6	6.6
General Internal Medicine	23.0	1.3	5.5
Internal Medicine Subspecialties	46.0	3.7	8.0
General Surgery	60.9	5.7	9.4
Surgical Subspecialties	33.0	1.5	4.5
Pediatrics	17.2	1.2	6.9
Obstetrics/Gynecology	46.2	2.3	4.9
Radiology	34.8	3.6	10.4
Psychiatry	20.0	1.7	8.5
Anesthesiology	37.2	2.4	6.4
Pathology	3.9	0.1	2.1 *
Emergency Medicine	95.2	22.9	24.1
Other Specialties	11.5	1.0	9.0
CENSUS DIVISION			
New England	31.5	2.2	7.0
Middle Atlantic	27.2	1.8	6.5
East North Central	30.4	2.9	9.6
West North Central	25.3	1.9	7.6
South Atlantic	31.3	3.0	9.5
East South Central	38.1	3.9	10.4
West South Central	40.3	3.5	8.7
Mountain	37.4	2.8	7.6
Pacific	30.4	3.1	10.3

Notes: [a] Differences across specialty and census division statistically significant at $p<0.010$. [b] Differences across specialty statistically significant at $p<0.010$. [c] Differences across census division statistically significant at $p<0.050$. * Mean is based on fewer than 25 observations.
Source: 2001 AMA Patient Care Physician Survey.

Table 2. Distribution of Emergency Medicine Physicians by Provision of EMTALA Mandated Care, 2001

Hours of EMTALA Mandated Care Per Week	Percent of Physicians
1-10	38.0%
11-20	12.9
21-30	12.9
31-40	19.8
41+	16.4

Source: 2001 AMA Patient Care Physician Survey.

Table 3. Financial Impact of EMTALA on Physicians, 2000

	Percent of Physicians With EMTALA Related Bad Debt [a]	Percent of Bad Dept from EMTALA [a]	Level of Bad Debt from EMTALA [a]
All Physicians	42.3%	13.7%	$12,300
SPECIALTY			
General/Family Practice	31.0	8.9	4,700
General Internal Medicine	34.0	10.8	7,000
Internal Medicine Subspecialties	60.3	21.0	26,900
General Surgery	76.3	27.5	25,600
Surgical Subspecialties	54.3	17.4	13,500
Pediatrics	23.0	4.5	2,400
Obstetrics/Gynecology	52.3	10.2	4,100
Radiology	46.5	15.8	22,000
Psychiatry	11.3	3.9	1,200
Anesthesiology	68.6	27.0	16,500
Pathology	13.2 *	0.8 *	3,400 *
Emergency Medicine	100.0 *	61.0 *	138,300 *
Other Specialties	18.6	4.9	4,500
CENSUS DIVISION			
New England	31.6	7.4	3,800
Middle Atlantic	35.0	11.9	6,400
East North Central	39.6	10.4	9,100
West North Central	41.4	9.8	2,400
South Atlantic	42.0	15.7	16,600
East South Central	59.3	21.3	28,600
West South Central	53.1	20.3	14,300
Mountain	50.7	17.7	28,300
Pacific	41.1	10.8	9,400

Notes: [a] Differences across specialty and census division statistically significant at $p<0.010$. * Mean is based on fewer than 25 observations.
Source: 2001 AMA Patient Care Physician Survey.