

Beyond the Safety Net: America's Emergency Departments Keep the System Afloat

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America's emergency departments (EDs) are vital to our health care system. As the entry point for those who lack insurance coverage and the acutely injured or seriously ill, emergency departments care for any patient who comes through the door. America's EDs see 130.4 million patient visits per year — that's 41.9 visits per 100 persons.^[1] Emergency departments control costs for hospitals and health care systems, since only 9.3% of those visits result in hospital admission. Emergency physicians make critical gate-keeping decisions regarding the safest, most appropriate, and most cost-effective way to care for each patient — with far-reaching consequences for those patients and the entire health care system.

Because of EMTALA, the Emergency Medical Treatment and Active Labor Act of 1986, EDs also carry a heavy charity burden. EMTALA requires that EDs provide necessary care to every patient who comes in, regardless of that patient's ability to pay for such care and without regard to the patient's insurance status. With EMTALA, Congress made America's EDs our nation's medical safety net. And although Congress has never provided funding for this mandate, the physicians, nurses and other health care team members who work in EDs continue to perform this vital function. According to a 2003 report from the Center for Health Policy Research, the average emergency physician in the United States donates about \$140,000 each year in uncompensated EMTALA-mandated care — more than ten times the all-specialty average.^[2]

One of the most important principles supporting the medical safety net is the “prudent layperson” standard for defining an emergency, which requires health insurance plans to base reimbursement on a patient's presenting complaint rather than the final diagnosis. It defines an emergency medical condition as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in — (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part.”^[3]

This means insurers must cover emergency department care, for example, when a patient's severe chest pain turns out to be heartburn rather than a heart attack. Such a determination often takes hours, multiple diagnostic tests, and the considered judgment of an experienced emergency physician. Under the prudent layperson standard, insurers cannot use the final diagnosis as an excuse to deny coverage. Senator Benjamin Cardin (D-MD) sponsored the original bill setting this standard, which was added to Medicare and Medicaid regulations a few years later in the Balanced Budget Act of 1997. The Affordable Care Act (ACA) applied this standard to nearly 100% of health plans. More than 35 national medical organizations support this standard. In addition, one large study using data from 35 states found “no evidence in any models that passage of a prudent layperson mandate was associated with increases in ED use,” despite fears to the contrary.^[4]

Emergency physicians are deeply concerned that if emergency care is not protected in current and future health care legislation, the safety net will come apart and leave all patients in danger — insured and

uninsured alike. The American Health Care Act of 2017 (AHCA), does not drop required coverage for emergency medical conditions or change the prudent layperson standard. However, it does allow states to apply for a waiver that would allow those states to define their own required benefits packages. Therefore, a state could apply to drop required coverage of emergency care or eliminate the prudent layperson standard.

The prudent layperson definition of medical emergency **must** be retained and no state should be allowed to alter it. Without this standard patient safety is at risk. Any financial factor that gives a patient pause when considering whether to seek emergency treatment is dangerous. I've seen the 60 year-old diabetic who waits to present with his infected foot wound lose his leg as a result. I've also cared for the broke graduate student who attributes her shortness of breath to a virus and ends up on a ventilator in the ICU for necrotizing pneumonia. Emergency physicians train specifically to find the grenade hiding amongst the long line of benign-sounding back pains, red eyes and headaches – the diagnoses that can leave you paralyzed, blind or dead. Many patients, even those with insurance, will avoid care if they fear coverage denial in the event their chest pain turns out to be heartburn instead of a heart attack.

Emergency departments cannot remain viable if the prudent layperson standard is threatened. If insurance companies refuse payment for emergency care, as some are attempting right now in Kansas, Missouri and elsewhere despite federal and state law,^[5] we risk widespread hospital closures and the destruction of our nation's medical safety net. The alternative is that state and federal governments make up the difference. The medical safety net must be funded, otherwise emergency departments and then entire hospital systems will close, leaving patients with no place to go.

The emergency department is not the solution to every health care problem. We do not provide primary care or follow-up care. We do provide emergency care for all, however, regardless of age, sex, race, nationality, pre-existing conditions, and ability to pay. For us to continue this crucial service to our patients, the prudent layperson standard and guaranteed coverage of emergency medical care must be preserved.

[1] National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary Table. Tables 1, 4, 14, 24.

[2] Kane CK. Physician Marketplace Report: The Impact of EMTALA on Physician Practices. American Medical Association, 2003.

[3] Li J, Galvin HK, Johnson SC. The "prudent layperson" definition of an emergency medical condition. [Am J Emerg Med.](#) 2002 Jan;20(1):10-3.

[4] Hsia R, Chan J, Baker L. Do Mandates Requiring Insurers To Pay For Emergency Care Influence The Use Of The Emergency Department? *Health Aff* July 2006 vol. 25 no. 4 1086-1094

[5] Singleton Craig C. New Concerns Arise Over Application of Prudent Layperson Standard in the ED. May 2017. <http://www.ciproms.com/2017/05/new-concerns-arise-over-application-of-prudent-layperson-standard-in-the-ed/>