Reimbursement, Regulations, Recession and Emergency Care

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When a constituent at the second presidential debate held on October 7, 2008 asked whether health care should be treated as a commodity, neither presidential candidate directly answered the question.¹ But health-insurance marketplace trends show that healthcare is heading toward more market competition…at least for now.² The trend for high-deductible health plans demonstrates the movement towards competition.³ Consequently, alternative treatment settings such as retail stores, urgent care facilities, and emergency centers have emerged, competing directly with the primary care physician’s office and hospital-based emergency departments.⁴

Undisputedly, hospital-based emergency rooms across the country are overcrowded, ambulances are turned away, and patients, once admitted, may wait in hallways for hours or days.⁵ The emergency room provides medical care for the uninsured, but it also used to be a place where paying and insured patients went on evenings and weekends when their regular physicians’ offices were closed.⁶ One common complaint is that many patients use the emergency room even though they are not suffering from critical, life-threatening injuries or illnesses. The emergency room should be the place where patients turn only when life support is needed. The hospital emergency department, however, relies on receiving facility fees as part of its payment for treating non-critical patients who have insurance or the ability to pay out-of-pocket. But now, these paying patients have more viable alternatives to treatment at the emergency room, including retail clinics, urgent care centers, and freestanding emergency centers.

Since 2000, approximately 1,000 retail clinics have appeared across the country in stores such as Wal-Mart, pharmacy chains like Walgreens and CVS, grocery stores, and even airports.⁷ Initially, these clinics did not accept insurance and charged a flat fee ranging between $40-70. Now, most retail clinics accept insurance or at least provide the

⁴ Amanda Gengler, Milk, Bread, Newspaper…and a Flu Shot?, MONEY, Jan. 1, 2009, at 78.
⁶ Id.
⁷ Daniel Costello, Report from the Field: A Checkup for Retail Medicine, 27 Health Affairs 1299 (October 2008).
customer with the proper information needed to submit a claim for reimbursement. These clinics provide the uninsured with an affordable option for access to healthcare as most people can afford the nominal fee, which helps the emergency room lessen its burden. But in reality, these retail clinics compete with the emergency room and draw paying patients away from hospital emergency departments.

Urgent care facilities are another breed of clinics designed to fill the gap between retail clinics or physicians offices and emergency rooms. The Urgent Care Center of America defines an urgent care center as providing “walk-in, extended hour access beyond the scope or availability of the typical primary care clinic.” In most states, an urgent care center does not need a license. However, these centers may be subject to the same regulations as a physician’s office depending on the state. States also may regulate the signage on an urgent care facility. Because an urgent care facility is not heavily regulated, the care it provides is more efficient than a hospital emergency department and more cost effective. Unlike emergency departments, however, urgent care facilities may not charge facility fees. Instead, urgent care facilities receive a flat-fee, global reimbursement rate regardless of the treatment provided even though treatment at these facilities usually is more intensive than what a typical physician’s office or retail clinic is able to offer. For example, many urgent care centers can treat acute injuries such as broken bones, a heart attack, and dehydration. Insurers, recognizing the value of these additional services, now permit urgent care clinics to bill for the extra cost associated with these services. Reimbursement rates for these add-on fees range from zero to $100.00. Some argue that an urgent care center should receive a nominal facility fee given that a hospital emergency department charges these patients an enormous facility fee. Although intended as a more convenient, cost-efficient treatment alternative, urgent care facilities skim those patients who have an urgent medical need as opposed to a true emergency from the hospital emergency department, depleting the coffers for emergency departments, which are left with uninsured and seriously ill or trauma patients who require the most expensive treatments.

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10 About Urgent Care, http://www.ucaoa.org/home_abouturgentcare.php
11 http://www.ucaoa.org/resources_newturgentcare.php; ARIZ. REV. STAT. § 20-1077
12 http://www.ucaoa.org/resources_newturgentcare.php; See, e.g., ILL. COMP. STAT. § 70/2.
13 Id.
15 Id.
17 Id.
18 Id.
To add to emergency department’s woes, freestanding emergency centers have made national headlines emerging on the healthcare scene as a direct competitor for paying patients. Drivers on the major freeways in areas surrounding Houston, including Sugarland, Pearland, and Katy, have “EMERGENCY CENTER” signage on what formerly were office buildings. These emergency centers, unlike most urgent care facilities, are often open 24-hours a day and meet the same criteria for a hospital-based emergency center. A significant difference is most are not licensed by the state as a hospital; therefore, these freestanding emergency centers avoid the bureaucratic red tape. While the providers have no issues receiving reimbursement for their services in these settings, health plans and third-party payors hesitate to reimburse the emergency care centers any facility fee despite the fact that the many freestanding emergency centers are comparable to a hospital emergency department. But when health plans or third-party payors refuse to pay these fees, these facilities may have no choice but to turn to the patients themselves for payment.

High deductibles and increased out-of-pocket expenses have already increased the economic burden for health-care consumers, but health plans and third-party payors refusal to pay for facility fees transfers the risk assumed by these health plans and third-party payors to the consumer. These innovative healthcare systems undisputedly relieve the congestion at the emergency department, but at what cost? Critics present cogent arguments that the market left unregulated would lead to the crash of the hospital emergency department. One reason that hospitals are critical to the American healthcare system is because federal statutes impose a duty on hospital emergency

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[22] The Texas legislature by passing the Texas Prompt Pay Act attempted to help providers receive reimbursement for emergency healthcare services, but many patients are covered under employee benefit plans and the statute does not apply to those plans.


departments to provide certain emergency medical care under the Emergency Medical Treatment and Active Labor Act (“EMTALA”) regardless of the patient’s ability to pay.\(^{26}\) Millions of Americans rely on the emergency department as their only point of access to healthcare. This number is anticipated to climb due to the economic recession and with people losing their jobs. If freestanding emergency care centers, retail clinics, and urgent care centers are able to divert paying patients away, the emergency department—the last and only resort for millions—could vanish.\(^{27}\) As Alan Beyer, the President and Chief Executive Officer of Akron General Health Systems explained, hospitals “\textit{need to have paying patients to continue serving all who walk through the doors and offset some of the losses that we incur from those who are uninsured and indigent. That balance clearly is in jeopardy.}”\(^{28}\) Hospitals, in other words, are left with more complicated, costly cases such as pregnancies, trauma patients, and pending organ failure while paying patients with less complicated illnesses are siphoned off by the concierge facilities. Setting aside quality-control issues due to the inability of consumers to truly make an informed choice when it comes to their healthcare,\(^{29}\) the stark consequence of treating healthcare purely as a commodity could result in those without the resources for concierge emergency care having no point of access into the healthcare system.\(^{30}\)

While wonks hash out these important policy issues regarding quality control and access, healthcare consumers are footing the bill. Regulations intended to help with the healthcare crises unintentionally contributed to problem by promoting the emergency room to be a point of access in the healthcare system rather than the primary care physician. Additionally, EMTALA is an unfunded mandate. And any state regulations regarding reimbursement for emergency care apply only to a minority of insurers due to federal preemption of state regulations for employee benefit plans. These alternative settings certainly provide a valuable service given the overcrowded and costly medical care provided at hospital emergency departments. But the issue raised in the presidential debate—whether healthcare is a commodity or a fundamental right—becomes more apparent and more important when more competition enters into the healthcare marketplace, deductibles for insurance increase, and consumers become more frugal on spending.


\(^{26}\) 42 U.S.C. §1395dd.
\(^{29}\) Hall and Schneider, \textit{supra}, fn.2.
\(^{30}\) Sandra Carnahan, \textit{Law, Medicine, And Wealth: Does Concierge Medicine Promote Health Care Choice, or Is It A Barrier To Access?}, 17 STAN. L. & POL’Y REV. 121, 155 (2006).