The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SM 1746
INTRODUCER:	Health Regulation Committee and Senator Jones
SUBJECT:	Emergency Room Staffing Initiative
DATE:	March 4, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harper	Wilson	HR	**Fav/CS**
2.			HA	
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This Senate Memorial urges the United States Congress to create a nationwide initiative to remedy the existing crisis of an insufficient number of physicians and medical specialists to provide on-call emergency room support by amending the nation's tax code to allow for all uncompensated emergency room work to be eligible as a charitable deduction against earned income for the practicing physician or medical specialist, up to a maximum of $100,000.

This Senate Memorial does not amend, create, or repeal any provisions of the Florida Statutes.

II. Present Situation:

The availability of physicians, especially physician specialists, in hospital emergency departments (EDs) has been a concern in Florida and nationwide for several years. The Florida Senate Committee on Health Regulation studied this situation in the 2007-2008 interim and issued Interim Project Report 2008-138, *Availability of Physicians and Physician Specialists for Hospital Emergency Services and Care* in November, 2007.[1] The report found that there are

[1] This report is available at:< http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-138hr.pdf > (Last visited on March 2, 2010). An addendum to the report was subsequently published and is available at:

multiple reasons why physicians are unavailable for on-call coverage in hospital EDs and the problem varies by locality, specialty, and hospital. However, in general, physicians are reluctant to provide emergency on-call coverage due to the negative impact on their lifestyle, the perceived hostile medical malpractice climate, and the inability to obtain adequate compensation for services rendered. All of these reasons are disincentives to assuming liability for treating emergency patients previously unknown to the physician. In some cases, however, the problem is simply an inadequate supply of a particular type of specialist in the market.

Among the consequences of having fewer on-call emergency providers is reduced patient access to timely specialty care in the nation's EDs. The findings of a 2006 report by the American College of Emergency Physicians' (ACEP) Emergency Medicine Foundation indicate that "on-call coverage in the nation's EDs has deteriorated and public policymakers should take note of the largely unintended consequences of the regulations governing the Emergency Medical Treatment and Labor Act (EMTALA)."[2]

Federal Emergency Medical Treatment and Labor Act[3]

In 1986, Congress enacted the EMTALA to ensure public access to emergency services regardless of a person's ability to pay. The EMTALA applies to hospitals with an ED that participate in the Medicare program. The EMTALA specifies that a hospital with an ED must provide for an appropriate medical screening examination to determine whether an emergency condition exists for any individual who comes to an ED and requests examination or treatment of a medical condition. If an emergency medical condition exists, the hospital must provide, within the staff and facilities available at the hospital, further medical examination and treatment as may be required to stabilize the medical condition for transfer of the patient to another medical facility or discharge.

Emergency Departments

From 1996 to 2006, the number of people needing emergency care annually increased 32 percent, from 90.3 million to 119.2 million. At the same time, the number of hospital EDs in the country has dropped nearly 7 percent, from 4,109 to 3,833.[4] The Centers for Disease Control and Prevention (CDC) has reported that the elderly population of emergency department users, who have the largest share of serious emergency medical conditions, is about to soar as baby boomers reach Medicare age. The CDC forecasts that this group will fuel demand for more specialty care in EDs.[5]

<http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-138ahr.pdf> (Last visited on March 2, 2010).

[2] American College of Emergency Physicians (ACEP). "On-Call Specialist Coverage in U.S. Emergency Departments." ACEP Survey of Emergency Department Directors, April 2006.
Available at: <http://www.acep.org/WorkArea/downloadasset.aspx?id=33266> (Last visited March 2, 2010).

[3] Section 1867 of the Social Security Act, 42 U.S.C. s. 1395dd.

[4] ACEP. The National Report Card on the State of Emergency Medicine. 2009. Available at:
<http://www.emreportcard.com/uploadedFiles/ACEP-ReportCard-10-22-08.pdf.pdf> (Last visited March 2, 2010).

[5] Centers for Disease Control and Prevention (CDC). National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary. *Advance Data*, No. 358, May 2005. Available at: <http://www.cdc.gov/nchs/data/ad/ad358.pdf> (Last visited March 2, 2010).

Uninsured Emergency Department Patients

According to federal government estimates, approximately 46.3 million Americans, or 15.4 percent of the population, were uninsured in 2008.[6] Uninsured persons and underinsured persons are more likely to forgo needed medical care until an emergency arises. Physicians carry the financial risk of providing care to uninsured or underinsured patients they treat in EDs. Since many of the patients seen in hospital EDs are uninsured or underinsured, physicians are less likely to be reimbursed for services they provide in EDs, and physicians are increasingly reluctant to provide services in hospital EDs without adequate compensation. According to the ACEP, emergency care physicians provide on average $140,000 in uncompensated care annually.[7]

Medicare Reimbursement Rates

Medicare was established in 1965 under Title XVIII of the Social Security Act, as a social insurance program to provide health and financial security for people age 65 or older, people under age 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). Medicare reimburses providers based on the type of service they provide. The Centers for Medicare and Medicaid Services (CMS) develops annual fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies. Hospital Medicare providers are paid via a prospective payment system (PPS). The PPS is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the diagnosis-related groups (DRGs) classification system.

III. Effect of Proposed Changes:

This Senate Memorial urges the United State Congress to create a nationwide initiative to remedy the emergency room on-call staffing crisis by amending the nation's tax code to allow for all uncompensated emergency room work to be eligible as a charitable deduction against earned income for the practicing physician or medical specialist up to a maximum of $100,000.

The memorial specifies that charges eligible for the charitable deduction should be based on a rate equivalent to 200 percent of the Medicare reimbursement rate at the time the service is rendered. In the absence of an applicable Medicare billing code, the charge for this deduction should be based on a fee not to exceed 100 percent of the average customary and reasonable charges allowed under private health insurance for any services rendered.

Copies of the memorial are to be provided to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, and each member of the Florida delegation to the United States Congress.

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[6] U.S. Department of Commerce, Economics and Statistics Administration. "Income, Poverty, and Health Insurance Coverage in the United States: 2008." September 2009. Available at: <http://www.census.gov/prod/2009pubs/p60-236.pdf> (Last visited March 2, 2010).

[7] See: ACEP, Health Care Reform Fact Sheet. Available at: <http://www.acep.org/pressroom.aspx?LinkIdentifier=id&id=45294&fid=3496&Mo=No&taxid=112443> (Last visited March 2, 2010).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Regulation on March 4, 2010:
The Committee Substitute clarifies that, if there is no Medicare billing code, the charge that is specified in the bill is for the physician charitable tax deduction not what the hospital may charge.

B. Amendments:

None.