EDITORIAL

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Safety Net or Trampoline?

Only a few years after emergency medicine became a specialty, references to emergency departments as "safety nets" began to appear. The term was meant to indicate the role of the ED in catching patients falling through holes in the health care system and sometimes also to express a need for national health insurance to provide more appropriate sources of nonemergency care. Most of us thought that national health insurance would become available in this country on the "twelfth of never," and have long ago accepted the role of the ED in treating any patient who arrives for care. Ironically, now that national health insurance is upon us, use of the ED has increased even further. One reason is that the Patient Protection and Affordable Care Act (PPACA) includes no measures to increase the number of providers; another reason is that few alternatives to ED care are currently available, especially during "off hours."

If the purposes of safety nets are both to catch those who fall and afterwards allow time to figure out how to prevent future falls, we have failed miserably in the latter. Punishing the patients and providers by restricting ED care or withholding payments is the worst possible way to discourage repeated use of EDs for nonemergencies. The best ways are to ensure the availability of other providers at all times and compensate them adequately for the care they provide.

But the underlying problems causing patients to repeatedly "bounce" into EDs have largely been ignored for over 40 years. Since 1986, EDs have been mandated by federal EMTALA law to evaluate and medically stabilize all patients. When managed care organizations subsequently tried to restrict their clients' ED care by requiring preauthorization and denying reimbursement for conditions retrospectively considered "nonemergencies," EMTALA was strengthened in 1994 to mandate emergency care (and payments) based on a "prudent layperson definition" of an emergency. In 1997, the law was further strengthened to require application of the prudent layperson definition to Medicaid managed care, as well.

Ironically, despite the enactment of PPACA, access to ED care for many may be significantly worse. Medicaid is a large component of PPACA, and at least 43 states currently restrict Medicaid reimbursement for ED care, with Washington state trying to enact the most draconian cuts based largely on final diagnoses. In effect, states are now challenging the federal government's prudent layperson definition of an emergency in the hope of cutting their Medicaid expenditures for ED care.

But even with EMTALA compliance, if a patient with a medical problem comes to an ED because no other source of care is readily available, and the mandatory screening exam reveals a "nonemergent" condition, is it reasonable to stop there and make the patient go elsewhere for continued treatment or pay out of pocket for continued ED care? Or instead, should government ensure the availability of more attractive walk-in alternatives 24/7?

If EDs are becoming more of a trampoline than a safety net, don't blame patients who have no real alternatives. But if you insist on doing so, at least include all of the other contributors to the problem: those who send patients to EDs to wait for inpatient beds, those who pressure physicians and hospitals to discharge patients too early—causing return visits to EDs a few days later—those who close free clinics or transform them into pay clinics, those providers who won't accept any type of insurance payments up front, and those states that are sending increasing numbers of psychiatric patients to EDs by closing state inpatient facilities.

With all of these factors contributing to the large and growing number of patients vying for space to land on the safety net, it is inevitable that some will hit the rim or miss the net entirely. **EM**