REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8 - A-05
(June 2005)

Subject: Offsetting the Costs of Providing Uncompensated Care (Resolution 918, I-04)

Presented by: William H. Beeson, MD, Chair

Referred to: Reference Committee A (Alfred Herzog, MD, Chair)

At the 2004 Interim Meeting, the House referred Resolution 918. Resolution 918 (I-04) was sponsored by the following national medical specialty societies: the American Association of Neurological Surgeons, the American College of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Anesthesiologists, the Congress of Neurological Surgeons, and the Society for Vascular Surgery. The resolution calls for the AMA to: "work with the specialties affected by the costs of providing uncompensated care to develop legislative and regulatory proposals to help offset such costs for those physicians who provide care in emergency departments, trauma centers, and other settings; that such proposals include expanding to other specialties the methodology currently used by the Centers for Medicare and Medicaid Services to account for uncompensated care provided by the specialty of emergency medicine; and that our AMA seek financial support from affected specialties as necessary to complete any data collection that may be required to conduct these efforts." The Board of Trustees referred Resolution 918 (I-04) to the Council for study and a report back to the House at the 2005 Annual Meeting.

This report distinguishes between types of uncompensated care; enumerates the costs of providing uncompensated care in various specialties; discusses the methodology used to compensate the specialty of emergency medicine; describes the societal and other costs of so many individuals being uninsured; promotes covering the uninsured to decrease the level of uncompensated care; highlights an innovative program in Texas to offset the costs of uncompensated care; summarizes relevant AMA policies and reports; and provides several policy recommendations.

TYPES OF UNCOMPENSATED CARE

The AMA Socioeconomic Monitoring System survey, which was discontinued in 2001, distinguished between "charitable care" and "bad debt." Charitable care is defined as treatment that was provided without any expectation of receiving payment in full. Physicians may charitably offer a reduced fee to patients who have become uninsured or experience other personal difficulties. Bad debt, on the other hand, occurs when treatment was provided with the expectation of full payment, but with payment not being received. Whether patients fail to fulfill their cost-sharing obligation or health plans refuse to pay claims for services billed, physicians accumulate bad debt. Thus, for the purposes of this report, "charity care" is defined as care provided free or for a reduced fee due to the financial need of the patient; "bad debt" is defined as the value of services for which payment was expected but not received; and "uncompensated care" is defined as the sum of charity care and bad debt.

THE COSTS OF PROVIDING UNCOMPENSATED CARE

Although physicians provide an abundance of uncompensated care, typical estimates of uncompensated care minimize the care provided by physicians, and focus on that provided by hospitals. Table 1 summarizes data from the 2001 AMA Socioeconomic Monitoring System survey. The first two columns of Table 1 show, by specialty, the percentage of physicians who provided charity care in 2001, and the average number of hours per week those physicians spent providing such care. The 64.5% of physicians who provided charity care in 2001 spent an average of 7.5 hours per week doing so. The average annual value of charity care provided by physicians in that group was $54,468. Specialty-specific estimates of the value of charity care are not precise enough to be reported because of sample size limitations.

Applying the 64.5% of sampled physicians providing charity care to the population of non-federal, post-residency patient care physicians suggests that approximately 361,000 physicians provided charity care in 2001, with an aggregate value of charity care of $19.7 billion. The third column of Table 1 shows the average annual value of bad debt incurred by self-employed physicians. Across all specialties the average was $58,180. In 2001, approximately 341,000 physicians were self-employed leading to an aggregate estimate of bad debt of $19.8 billion.

Table 1. Physician Provision of Charity Care and Value of Bad Debt, 2001[1, 2]

	Percent of Physicians Providing Charity Care	Hours of Charity Care Per Week[3]	Bad Debt[4]
All Physicians	64.5	7.5	$ 58,180
SPECIALTY			
General/Family Practice	68.3	5.9	$ 35,792
General Internal Medicine	61.4	6.1	$ 37,179
Internal Medicine Subspecialties	71.9	7.2	$ 74,577
General Surgery	72.0	13.4	$ 95,355
Surgical Subspecialties	71.6	7.3	$ 75,373
Pediatrics	57.4	7.5	$ 40,015
Obstetrics/Gynecology	63.9	6.7	$ 40,786
Radiology	65.7	8.9	$ 115,950
Psychiatry	69.0	9.5	$ 12,900
Anesthesiology	63.5	11.3	$ 73,628
Pathology	52.7	7.2	-
Emergency Medicine	43.1	12.6	-
Other Specialties	58.2	4.8	$ 53,737

Source: 2001 AMA Patient Care Physician Survey

Notes: [1.] The estimates of bad debt from the 2001 survey are for the 2000 calendar year. They are used as estimates for 2001.

[2.] Values not shown when sample size is less than 25.

[3.] Among physicians who provided charity care.

[4.] Among self-employed physicians.

Accordingly, the value of uncompensated care provided by physicians in 2001 was $39.5 billion, which was split nearly evenly between charity care and bad debt. Yet, many estimates of

uncompensated care provided by physicians do not fully capture this magnitude of value. Physicians may use a variety of methods for calculating their level of uncompensated care. Some physicians may simply note "no charge" on the visit slip, whereas others may have a more structured procedure for documenting uninsured patients. Practices also will vary in the methods by which they account for bad debt. AMA data have consistently shown that physicians provide, on average, more than $2,000 worth of uncompensated care every week.

The Institute of Medicine (IOM) report "Hidden Costs, Value Lost: Uninsurance in America" (June 2003) reported that physicians "donate services" valued at $5 billion annually, an estimate that is often cited. In February 2003, Jack Hadley, PhD, and John Holahan, PhD, prepared a report for the Kaiser Commission on Medicaid and the Uninsured, which estimated that uncompensated care was valued at $41 billion annually, and estimated that physicians provide approximately $5 billion of that care. In May 2004, Hadley and Holahan prepared another report for Kaiser, and valued the physician component at $7.3 billion (18%) of $40.7 billion worth of uncompensated care in 2004. Although Hadley and Halohan cited the AMA data in their analysis, the authors chose not to include the bad debt component of physician uncompensated care. Therefore, there is a substantial difference between the AMA data and that used by Hadley and Holahan.

As detailed by Hadley and Holahan (2004), 85% of the "funding for uncompensated care" is governmental, with the majority (two-thirds) coming from the federal government. In turn, most of this funding is provided to hospitals as Disproportionate Share Hospital (DSH) payments. State governments also contribute to DSH. The other 15% (less than $8 billion in 2004) of uncompensated care, according to the Hadley and Holahan analysis, is provided by physicians and is truly uncompensated. Both state and local governments provide other non-DSH payments to hospitals, such as state and local tax appropriations and payments to hospitals. It is unknown whether physicians receive any portion of these payments.

METHODOLOGY FOR COMPENSATING EMERGENCY PHYSICIANS

The House of Delegates previously considered using elements of the Resource-Based Relative Value Scale (RBRVS) to offset the costs of providing uncompensated care, and concluded that while assessing the "value" of uncompensated care would be possible under the RBRVS, doing so would tarnish the medical profession with little chance of legislative success (Board of Trustees Report 49, I-93). Regarding the practice expense component of the RBRVS, the specialty of emergency medicine is compensated for its particular obligation under the Emergency Medical Treatment and Active Labor Act (EMTALA) to treat any patient regardless of ability or willingness to pay for treatment.

The methodology of the RBRVS acknowledges that EMTALA burdens falls most heavily on the specialty of emergency medicine. The EMTALA obligation, however, applies to every physician, regardless of specialty, who responds to an emergency room call. Therefore, although a payment mechanism exists for the specialty of emergency medicine, there is not an appropriate method for compensating EMTALA-directed care in the emergency room by other specialties.

At the 1999 Interim Meeting, Council on Medical Service Report 3 described the difficulty of ensuring emergency on-call staffing when there are inadequate payment methods. That report contained recommendations, adopted by the House, that supported enforcing existing laws and regulations to require physicians under contract with health plans to be adequately compensated for

emergency services provided to the health plans' enrollees (Policy H-130.948, AMA Policy Database). The report also called for the creation of a Board Task Force, which, through Board of Trustees Report 29 (A-00), recommended several AMA actions to assist individual physicians and medical staffs (Policy D-130.996).

OTHER COSTS OF HIGH UNINSURANCE RATES

In addition to the cost of providing care to the uninsured, recent efforts, such as a June 2003 report from IOM, have sought to highlight the value lost from having so many Americans without health insurance. Miller, Vigdor and Manning (March 2004) conducted the research cited in the IOM's June 2003 report, and estimated that the improved health from reducing uninsurance is valued in the range of $65 billion to $130 billion annually. In their analysis, Miller, et al. enumerated the costs to society, as well as the costs to individuals and their families and employers. Costs of uninsurance to society, the so-called "spillover costs," include negative effects on quality of health care, access to care, the public health system, population health (vaccine-preventable diseases), workforce productivity, "social norms of caring," and equal opportunity; as well as increased taxes and costs of public programs. Costs of being uninsured and uninsurance for individuals, families and firms, the so-called "private costs," include greater morbidity and premature mortality, developmental delays or losses for children, financial strain for families, diminished workplace productivity, and a "diminished sense of social equality and self-respect."

COVERING THE UNINSURED TO DECREASE UNCOMPENSATED CARE

A fundamental goal of the AMA proposal for health system reform is to increase the number of people with health insurance coverage, thereby decreasing the amount of uncompensated care. Redirecting funds currently spent to offset the cost of providing coverage for the otherwise uninsured, and redirecting those funds toward the purchase of health insurance coverage would be one mechanism for offsetting the costs of providing uncompensated care. There may be legitimate concerns that redirecting funds would reduce funds currently set aside for uncompensated care, such as DSH payments. If the uninsured become insured, however, payments for their care will be made to physicians, as well as to hospitals.

Therefore, the Council believes that a transitional shift of such resources would be a reasonable step forward. At the 2004 Interim Meeting, the House adopted Policy H-165.851, which supports incremental steps toward financing individual tax credits for the purchase of health insurance. One way of financing health insurance for the uninsured in a way that transitions from subsidizing hospitals to a system of subsidizing individuals, is to target subsidies to the uninsured who use the service of DSH-funded hospitals.

DSH payments are provided to hospitals that serve a disproportionate number of low-income Medicare and Medicaid patients with special needs. Physicians do not receive DSH funding directly. DSH payments take the form of either lump-sum payments or higher payment rates to hospitals. States have expended considerable energy and creativity in developing arrangements that maximize their allotment of federal DSH funds with few or no new state expenditures. Since DSH programs in many states are a source of revenue, limitations on these payments potentially reduce states' ability to finance other Medicaid services.
Aside from emergency medicine, there is no comparable provision for physician payment rates, and DSH payments do not necessarily offset the costs of providing uncompensated care by

physicians. While the Council appreciates the value of DSH payments to hospitals, it believes that some federal DSH payments should transitionally be redirected toward funding health insurance coverage for the uninsured. It is well understood that having health insurance results in better continuity of care and greater use of preventive services.

DESIGNATED TRAUMA FACILITY AND EMERGENCY MEDICAL SERVICES ACCOUNT

The American Society of Anesthesiologists (ASA), one of the sponsors of Resolution 918 (I-04), provided the Council with a description of a Texas program entitled the "Designated Trauma Facility and Emergency Medical Services Account (DTFEMS)." The DTFEMS funds trauma facilities, EMS firms and EMS/trauma systems via two traffic-related sources. One is state traffic fines and the other is a program that assesses a surcharge on the licenses of people based on an assessment of their accumulated driving infractions. According to information obtained from ASA, the first distribution of DTFEMS funds amounted to nearly $19 million statewide for Fiscal Year 2004.

DTFEMS is consistent with Policy H-160.971[2], which calls for the AMA to publicize the programs currently instituted to address uncompensated care and pursue additional solutions for dealing with the problem of uncompensated care. Similarly, Policy H-165.882[7] supports so-called "sin taxes" to address the issue of uncompensated care by supporting increased federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage. Physicians providing care in Texas trauma and emergency facilities do not receive direct funding from the DTFEMS program, although some physicians may have been able to negotiate payment from their hospitals. The Council appreciates ASA sharing information about the DTFEMS program.

AMA POLICIES AND REPORTS RELATED TO UNCOMPENSATED CARE

AMA policy related to uncompensated care includes opposition to physician tax subsidies for providing uncompensated care, and describes other possible ways to offset uncompensated care. Over the years, the House of Delegates has considered several resolutions requesting support for a tax deduction to offset the cost of uncompensated care. In response, the Board and Council repeatedly have presented detailed reports opposing the use of explicit tax deductions or credits to pay physicians for uncompensated care. In particular, Policies H-160.969 and H-180.965 oppose the use of tax deductions or credits for the provision of care to the medically uninsured and underinsured.

Policy H-130.948 addresses the difficulty of having sufficient call coverage of some specialties in some regions of the country, a situation that arose from insufficient or no compensation for being on call. It supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and supports legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA. In addition, Policy D-130.996, largely developed as a result of a Board Task Force, calls for numerous actions to assist individual physicians and medical staffs with their on-call coverage concerns. Finally, Policy D-130.997 calls

for the AMA to advocate payment for physician on-call services by hospital facilities, particularly when physicians are required to provide these services as a condition of medical staff privileges.

At the 2002 Interim Meeting, the Council presented an informational report which described the methods by which hospitals and physicians are paid for uncompensated care, as well as for teaching and research (Council on Medical Service Report 7, I-02). Numerous policies and directives support other means of offsetting the costs of providing uncompensated care. Data collection to highlight the prevalence of uncompensated care is supported by Policy D-70.981[2], which urges the AMA, in conjunction with state and specialty societies, to educate physicians about CPT codes that can be used to aid in the collection of EMTALA uncompensated care data; Policy H-160.965[2], which encourages county medical societies to study the nature and extent of medical care needed for the indigent in their counties; and Policy H-165.886[7], which urges state medical societies to collect information on, recognize, and publicize the pro bono activities of health plans. Policy D-440.985 calls for the AMA to assist states on the issue of the lack of reimbursement for care given to undocumented immigrants.

Policy H-165.886[1] urges physicians to share in the provision of uncompensated care to the uninsured indigent; and Policy H-165.886[4] encourages physicians to contract with health care plans that contribute in some way to care of the uninsured indigent and/or other community health needs, and that allow individual participating physicians to provide uncompensated care. At the same time, Policy H-165.886[5] encourages all health care plans that control the source of covered services and payment for such services to contribute to the care of the uninsured indigent or to other community health needs.

Recognizing the need to support increased funding to offset the cost of uncompensated care, Policy H-165.882[7,8] supports increased taxes on tobacco products and other sources of revenue earmarked for an income-related premium subsidy for purchase of private children's coverage. In addition, H-160.971[2] supports publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care.

The AMA proposal for health insurance reform, largely articulated in Policy H-165.920, was designed to promote coverage and choice for patients. The policy would empower patients to select coverage of their choosing and control when to use it.

DISCUSSION

As the data in this report indicate, physicians provide a significant amount of charity care and no financing system recognizes and compensates for it. Absent national health system financing reform, there are various means of offsetting the costs of providing uncompensated care, including projects such as the Designated Trauma Facility and Emergency Medical Services Account (DTFEMS) program and other supplementary tax programs. Programs designed to provide additional financing for the health care system should ensure that payment is directed to physicians who provide care related to the program. The Council believes that such programs should continue to be publicized as models for possible use in other states.

The AMA proposal for providing tax credits for the purchase of health insurance provides an ideal model for health insurance reform, so that previously uncompensated care would be compensated. Such an individually-based financing option, financed with funding currently used for public programs directed solely at hospitals, would greatly reduce the need for uncompensated care. This would change the public funding of the uninsured to a "front-loaded" system, where health insurance premiums are covered and all health care providers are paid, rather than a "back-loaded" system, where only hospitals are compensated.

The Council is wary, however, that billing for newly insured patients who previously were uninsured and whose treatment was previously uncompensated, may alarm those who monitor health care spending and had not accurately accounted for uncompensated care provided by physicians. Accordingly, the Council believes it is imperative to support the collection of accurate data to document the amount of uncompensated care that is provided by physicians, whether it is given as charity care or forfeited as bad debt. The Council believes it is unacceptable that many researchers fail to count charity care—care given freely by physicians—in their estimates of uncompensated care. By comparison, hospital care that is given freely is counted as uncompensated even though some of the care may be offset by DSH payments.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 918 (I-04), and that the remainder of this report be filed:

1. That it is policy of the AMA to support the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured. (New HOD Policy)

2. That the AMA support the use of innovative federal- or state-based projects that are not budget neutral, such as the Texas Designated Trauma Facility and Emergency Medical Services Account, for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care. (Directive to Take Action)

3. That the AMA encourage public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians. (Directive to Take Action)

4. That the AMA reaffirm Policy H-160.971(2), which calls for the AMA to publicize programs currently instituted to address uncompensated care. (Reaffirm HOD Policy)

References for the reports are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Support the transitional redistribution of public funds spent on uncompensated care and advocate that researchers accurately reflect the amount of uncompensated care provided by physicians, at an estimated total cost of $1,271.