The State of Emergency Care in California

"Currently, Emergency Physicians Medical Group staffs 14 Emergency Departments and hospital-affiliated urgent care facilities in California. **Recently, we terminated our physician staffing contracts with three hospitals** for various reasons, the most important one being the inability to fiscally staff emergency departments with board qualified physicians able to meet the demands of these counties.

All California counties have uncompensated care that emergency physician groups must write off on a daily basis. Many counties depend on emergency departments to care for their population because outpatient clinics do not exist or are unable to provide for the uninsured or indigent populations that contribute to the majority of uncompensated emergency care.

We are evaluating other sites in California and the feasibility of continuing services to these areas."

Patrice Palmaer, EPMG, 1/3/05

The emergency care safety net in CA is in trouble…..

“I came on duty this morning with

49 patients waiting to be admitted,

3 on ventilators.

Many beds closed due to nursing shortage.

I am hearing of a hospital in LA that is holding uninsured patients

in the ED for days at a time,

even when there are empty beds in their hospital.

ED docs are obviously upset but the hosp admin states they are breaking no rules.

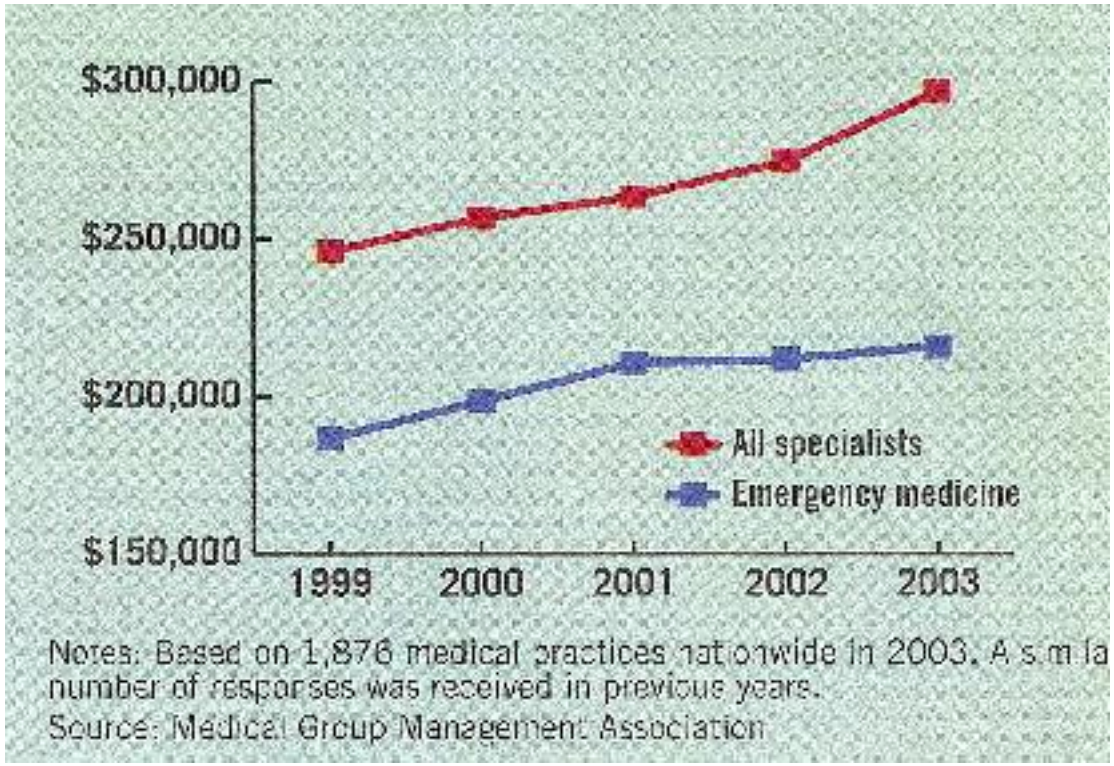
I don't even know where to begin to comment”.

Maureen McCollough, MD

New Challenges for Emergency Physicians in California

- 60 ERs closed in the last decade, 9 in the last year
- Inpatient bed shortages
- Admitted patients warehoused in ED for hours, even days
- Increasing numbers of uninsured and underinsured patients
- Fewer primary care providers taking new patients
- ED services increasingly broader and more complex
- Demands for higher patient satisfaction scores
- Nursing shortage puts greater demands on ED physicians
- Managed care expectations for patients to be treated, stabilized and discharged rather than admitted
- ED back-up panels shrinking
- More transfers and ambulance diversions

Emergency Medicine vs. Other Specialties



- Divergence is more pronounced in CA with larger Managed Care penetration
- Half of increase in ER physician income in CA related to closure of 45 ERs
- ER physicians account for less than 3% of all professional services fees

Health Plans Profit as ERs Fail

Insurer	Profits 2003	Change since 2000	Profit Margin increase
Aetna	$933.8M	635%	996%
Amerigroup	$67.2M	158%	5%
American Med Security	$29M	985%	1344%
Anthem	$774M	243%	79%
Cigna	$668M	-32%	-30%
Centene	$33.3M	363%	33%
Coventry Health Care	$250.1M	308%	134%
First Health Group	$153M	85%	5%
Health Net	$245M	43%	17%
Humana	$229M	154%	120%
Molina Healthcare	$42.5M	183%	18%
Oxford Health Plans	$352M	33%	0.20%
Pacificare	$243M	51%	55%
Sierra Health	$62.3M	131%	314%
United Health	$1.8B	148%	82%
WellChoice	$201M	5.60%	-17%
WellPoint	$935M	173%	24%

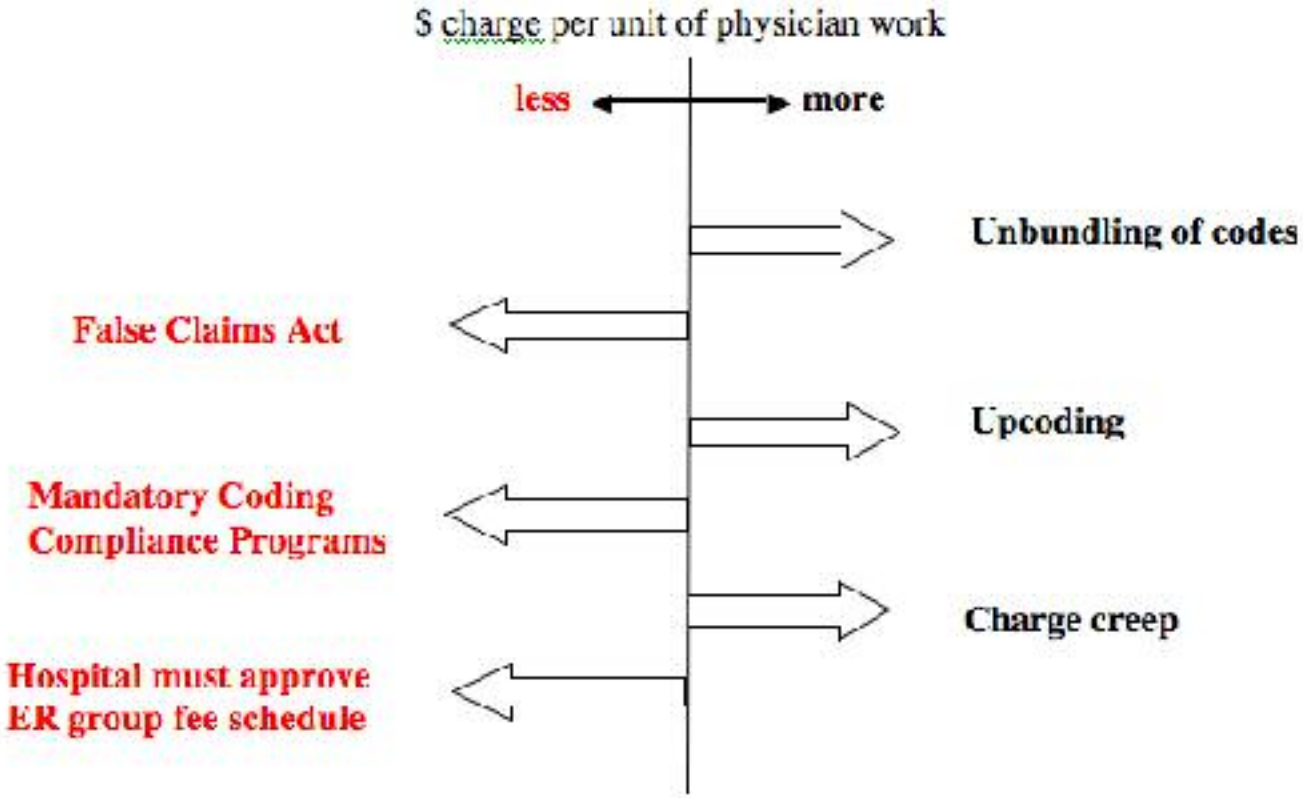
Source: CBS Marketwatch

In the last 3 years:

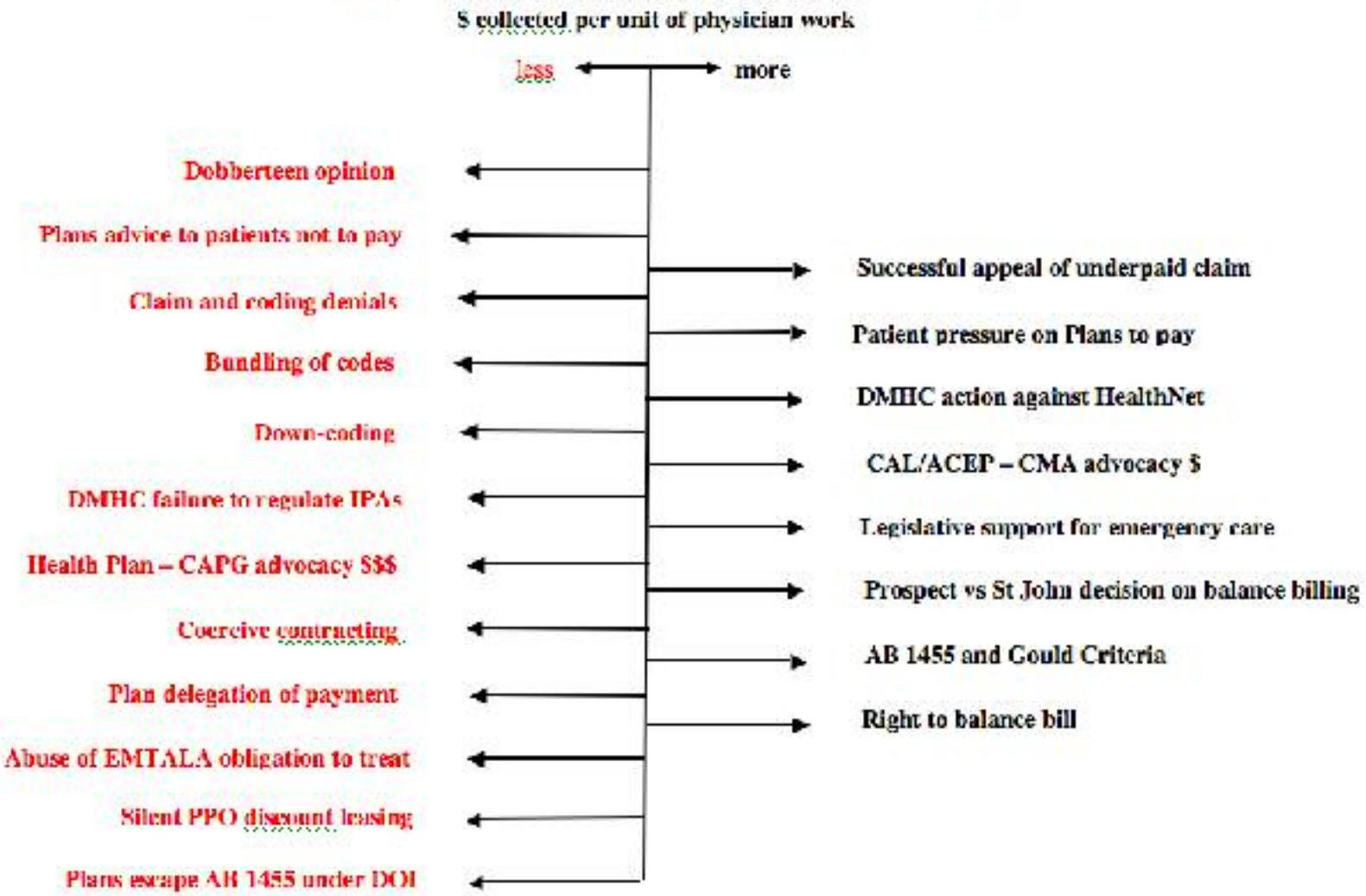
Health Plan Profits increase by 182%

17 Emergency Departments Close

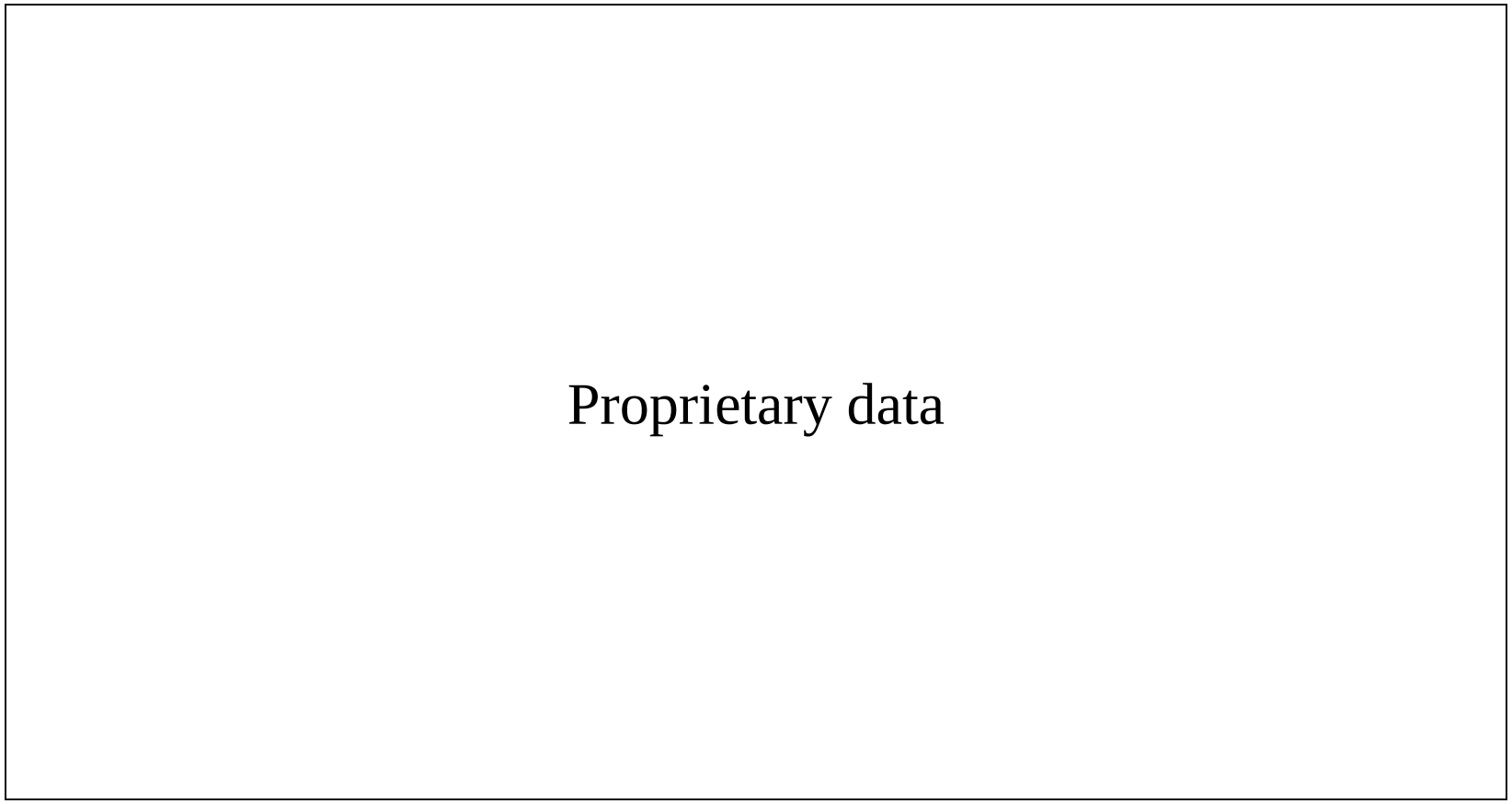
Factors that Affect Emergency Physician Charges



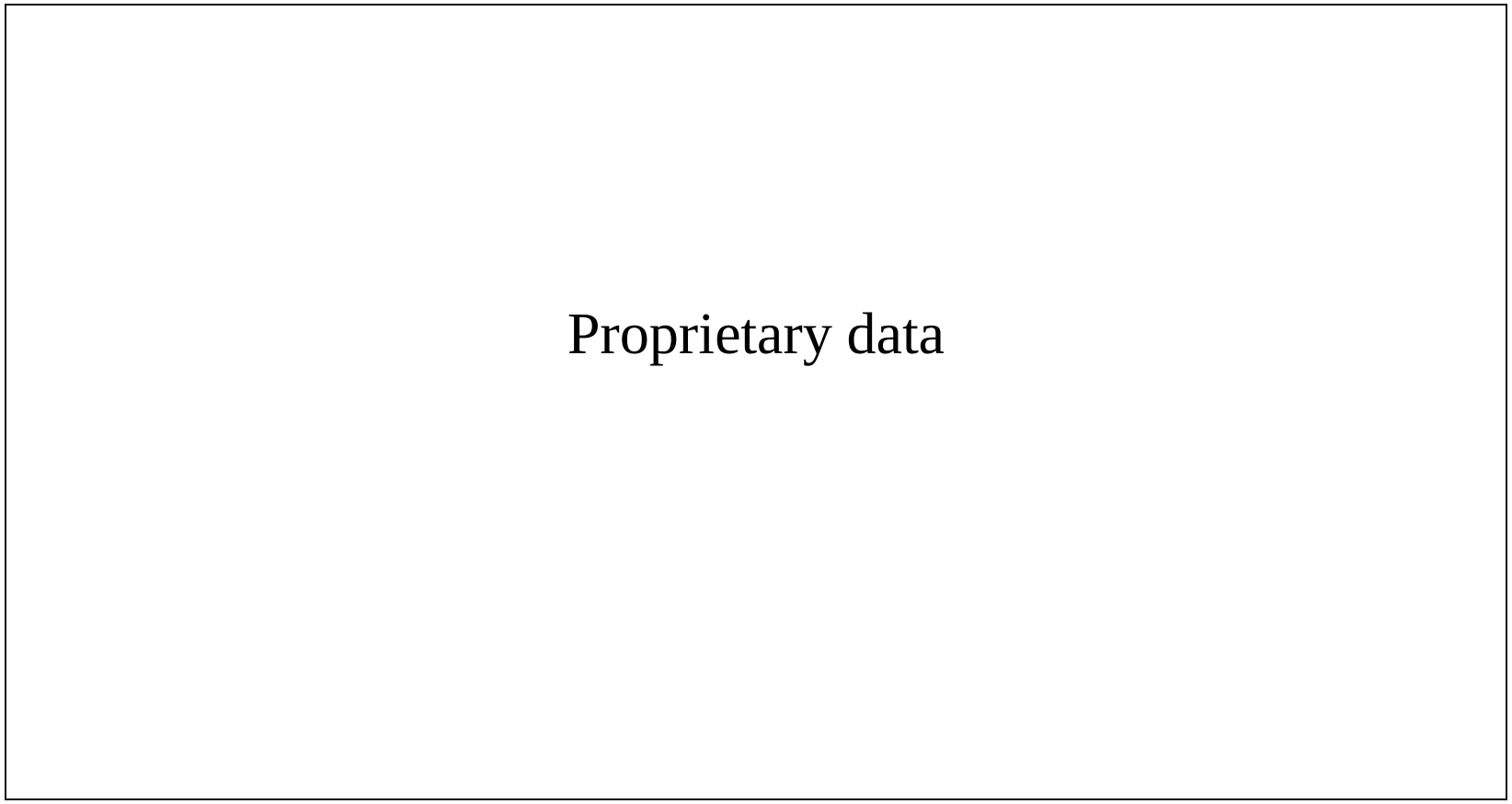
Factors that Affect Emergency Physician Reimbursement



CEP Contracts with IPAs / MGs



CEP Global Contracts with Health Plans



Why ER Groups Contract with Plans and IPAs

- Coercion from hospitals, sometimes bordering on illegal kickback scheme
- Fair-value partnership* with hospital and local IPA to increase patient volume

  * Hospital-ER contract requires negotiation for ‘fair market value’ of services with hospital’s payer network
- Some Plans and IPAs offer reasonable rates to ER groups (value recognition)
- Contracting may reduce claims disputes
- Pressure from colleagues on medical staff networked with IPA
- Fewer requests for copies of medical record with claim
- Eliminates hassles of balance billing
- Improves reputation of ER group as a willing partner with hospitals and medical community

Coercive Contracting

Suggestions by Cathy Kay, California Society of Healthcare Attorneys annual meeting, Mar 20, 2005, for hospital staffing contracts with hospital based providers:

a. Provider must agree to discount services comparable (or equal) to hospital's discount to networked payer

b. Provider must contract with all payors contracted with hospital

c. Provider must consider modifying its rates to facilitate hospital's ability to contract with payor

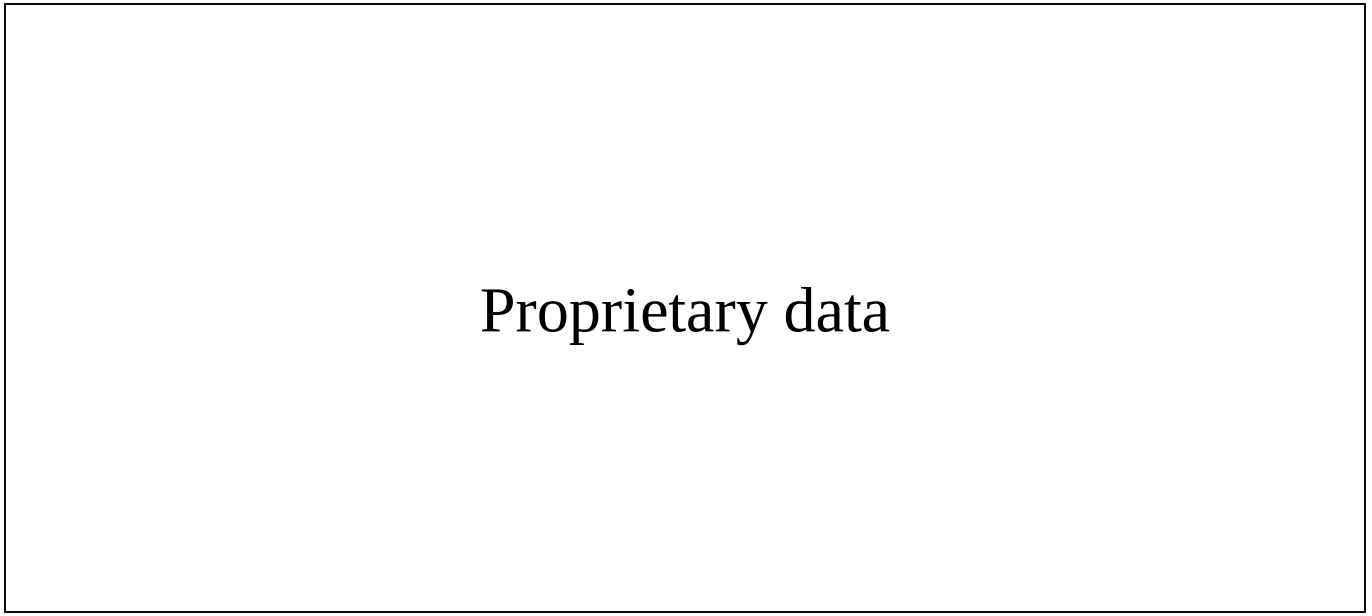
or face the consequences:

1. Hospital may terminate agreement with provider
2. Hospital may revoke provider's medical staff priviledges without the due process required in medical staff bylaws

Why ER Groups Don't Contract with Plans and IPAs

- No interest from Hospital in participating with IPA or Plan
- No increase in patient referrals anticipated
- IPA or Plan expects unreasonable discount or meet 'fair market value' requirement
- IPA or Plan has a history of poor performance, poor payment, or likely financial insolvency
- Failure of previous contract to reduce claims disputes
- IPA has poor reputation with colleagues on medical staff
- Plan or IPA suffers from management incompetence or worse
- ER group can't afford to deeply discount services for insured payers: too many uninsured patients
- Silent PPO arrangements

CEP % of A/R > 120 days by Payer Category



CEP AB 1455 Claim Disputes by Insurance Carrier
Mar-Dec, 2004 pg 1 of 23

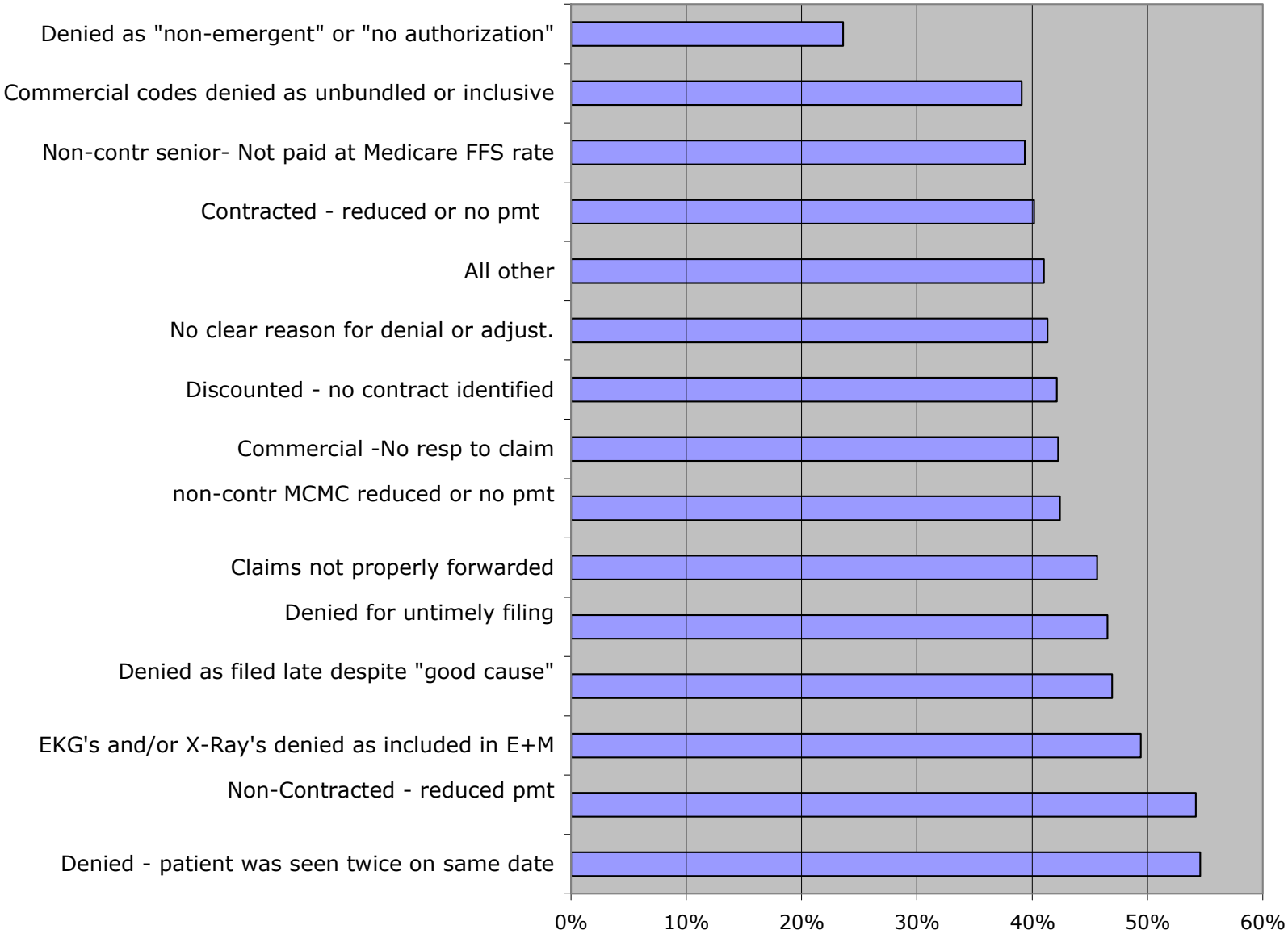
Ins Name	Paid		Unpaid		Total # Disputes	Total $ Paid Following PDR	% Of Disputes w/ Pmts Following Dispute
	# Disputes	$ Paid Following PDR	# Disputes	$ Paid Following PDR			
Proprietary data	9,628	$1,857,035	3,205	$0	12,833	$1,857,035	75%
	840	$87,219	2,479	$0	3,319	$87,219	26%
	1,360	$102,567	983	$0	2,343	$102,567	58%
	1,050	$66,673	996	$0	2,046	$66,673	51%
	1,745	$101,829	370	$0	2,115	$101,829	79%
	988	$62,274	612	$0	1,600	$62,274	62%
	688	$78,292	840	$0	1,528	$78,292	45%
	838	$116,531	466	$0	1,304	$116,531	64%
	800	$147,351	356	$0	1,156	$147,351	69%
	452	$41,515	658	$0	1,110	$41,515	41%
	313	$43,226	681	$0	994	$43,226	31%
	111	$16,971	719	$0	830	$16,971	13%
	87	$12,009	676	$0	773	$12,009	13%
	130	$13,667	628	$0	758	$13,667	18%
	297	$41,678	400	$0	697	$41,678	43%
	142	$16,669	536	$0	678	$16,669	21%
	17	$2,135	660	$0	677	$2,135	3%
	300	$19,744	236	$0	536	$19,744	56%
	86	$10,263	481	$0	567	$10,263	15%
	18	$1,727	619	$0	637	$1,727	3%
	82	$4,272	468	$0	627	$4,272	13%
	162	$17,703	362	$0	524	$17,703	31%
	256	$18,288	266	$0	622	$18,288	40%
	9	$1,402	466	$0	475	$1,402	2%
	260	$14,480	212	$0	472	$14,480	55%
	214	$30,024	246	$0	460	$30,024	47%
	320	$19,607	132	$0	452	$19,607	71%
	197	$30,760	245	$0	442	$30,760	69%
	153	$20,231	279	$0	432	$20,231	36%
	110	$8,741	286	$0	396	$8,741	28%
	34	$3,351	338	$0	372	$3,351	9%
	33	$5,722	237	$0	370	$5,722	14%
	176	$21,473	169	$0	344	$21,473	51%
	36	$2,618	279	$0	315	$2,618	11%
	83	$4,030	220	$0	303	$4,030	27%
	33	$1,553	274	$0	307	$1,553	11%
	84	$8,475	220	$0	304	$8,475	28%
	121	$9,039	118	$0	239	$9,039	42%
	41	$12,453	206	$0	247	$12,453	27%
	181	$22,564	74	$0	255	$22,564	71%
	9	$559	245	$0	254	$559	4%
	27	$350	223	$0	250	$350	11%
	15	$519	229	$0	245	$519	6%
	69	$8,531	156	$0	225	$8,531	31%
	134	$15,228	80	$0	214	$15,228	63%
	32	$1,535	181	$0	213	$1,535	15%
	138	$5,237	75	$0	213	$5,237	65%
	85	$10,460	116	$0	201	$10,460	42%
	83	$10,283	122	$0	205	$10,283	40%
	21	$1,827	181	$0	202	$1,827	10%
	84	$12,712	117	$0	201	$12,712	42%

CEP AB 1455 Claims Disputes Mar - Dec, 2004 - Summary

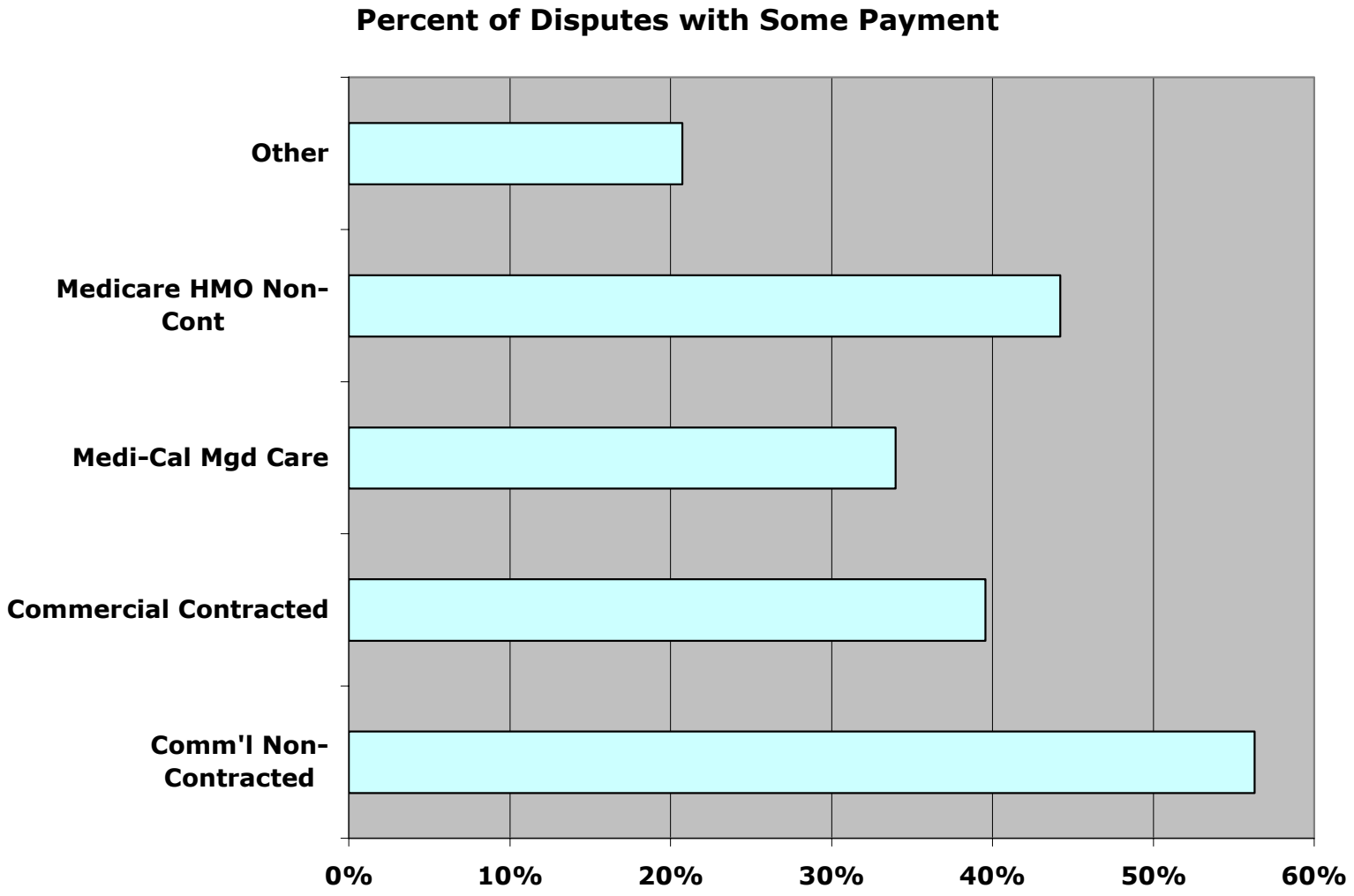
Paid		Unpaid		Total # Visits	Total $ Paid Following PDR	% Of Disputes w/ Pmts Following Dispute
# Visits	$ Paid Following PDR	# Visits	$ Paid Following PDR			
29,087	$3,931,303	34,182	$0	63,269	$3,931,303	46%

Reasons for Disputing Claim by Pmts Received

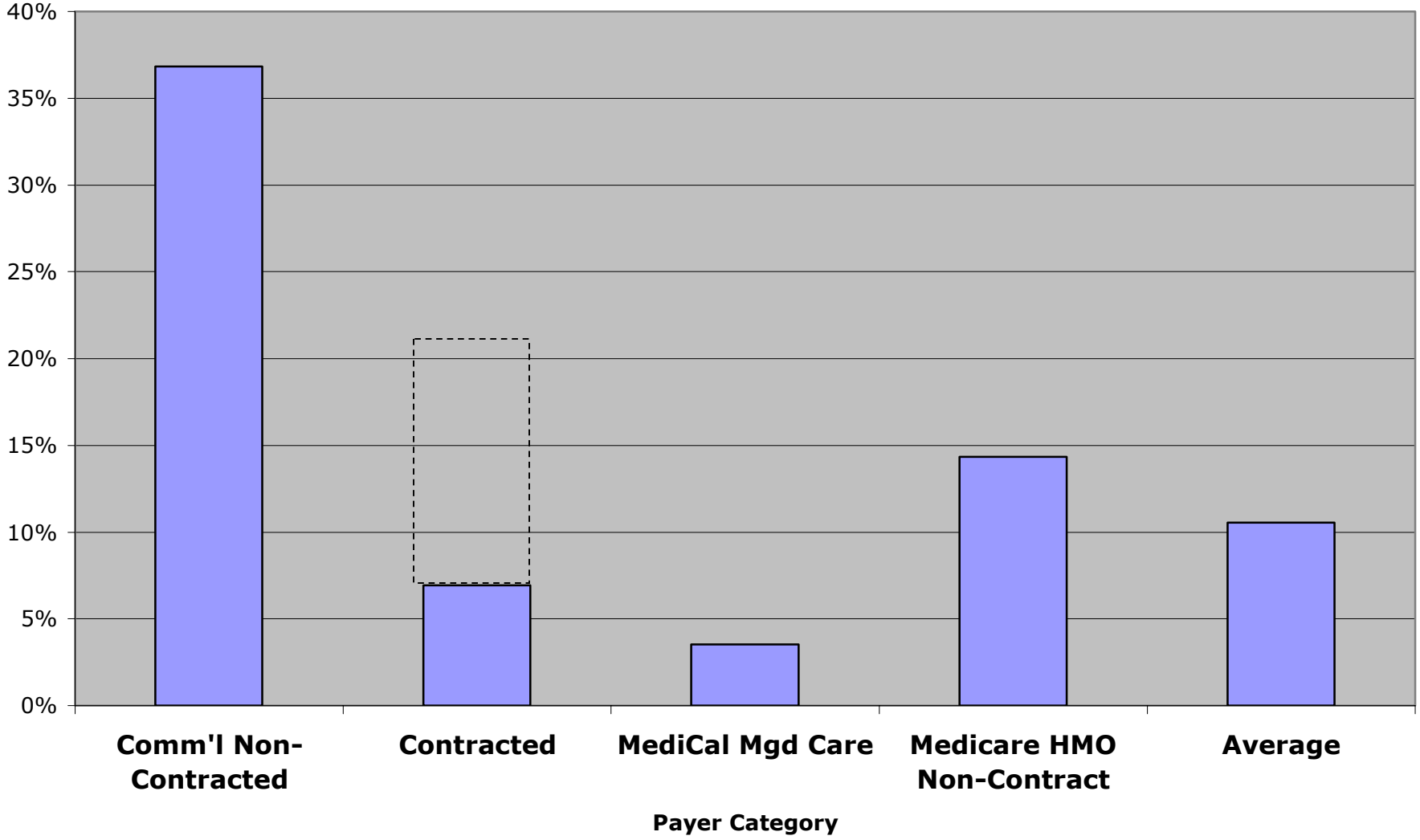
% of Disputed Claims Paid by Reason for Dispute



CEP Disputed Claims by Insurance Class Mar-Dec, 2004



Percent of Claims Disputed by Payer Category



Why Health Plans MUST Pay Their Fair Share to Support the Emergency Care Safety Net

- Emergency care is an essential service - without it managed care could not exist
- Medi-Cal provider payment lowest in US
- Growing population of under and uninsured
- Hospitals closing their ERs and/or down-grading services
- On-call specialists abandoning ER backup panels
- Increasing problem recruiting and retaining qualified Emergency Physicians in CA
- Health Plan capitation rates lowest in US
- Delegated model and coercive contracting squeezing EMTALA obligated provider reimbursement - most plans have never paid their fair share

Possible Solutions

- Enforcement of AB 1455 for all Plans and delegated payers
- AB 1455 for Department of Insurance regulated Plans
- Use Gould criteria to address outlier charges, not set fees
- Outlaw Silent PPOs
- De-delegate (carve out) emergency care services
- Enforct anti-kickback statutes to reduce coercive contracting
- Encourage three-way negotiations: hospitals, providers, and payers
- Require networks to contract with emergency care providers
- Preclude delegation for non-contracted emergency care services
- If provider is contracted with the Plan,

  and not the delegated payer,

  the Plan should pay the claim

The Bottom Line

- ER physicians are on the front line - we are the safety net for the uninsured and for managed care
- 9 ER closures in last year - 60 in last 10 yrs
- Health Plan profits have increased by 182% from 2000 to 2003
- Contracting must be a quid-pro-quo arrangement, not indentured servitude
- Profiteering at the expense of ethical providers harms patients and consumers
- The DMHC must counter-balance the EMTALA obligation with regulatory enforcement to ensure a fair marketplace for emergency care providers