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Laura D. Hermer

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## THE SCAPEGOAT: EMTALA AND EMERGENCY DEPARTMENT OVERCROWDING

*Laura D. Hermer*<sup>\*</sup>

### INTRODUCTION

There is one method of accessing healthcare in the United States that is available to each and every person therein, regardless of citizenship, wealth, race, ethnicity, gender, or insurance status. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), most hospitals with an emergency department (ED) are obliged under federal law to screen every person who seeks emergency medical attention, without regard to his ability to pay.<sup>1</sup> If the person is found to have an emergency condition that could result in serious bodily harm or death if left untreated, the hospital has a further duty to take whatever measures are necessary to stabilize the individual, again without regard to his ability to pay.<sup>2</sup>

Viewed from at least one perspective, the goals of EMTALA are admirable. Congress enacted EMTALA in 1986 as a response to perceived widespread patient dumping by private EDs, often onto public EDs.<sup>3</sup> Public hospitals, which often rely on significant local and state subsidies for funding, traditionally have a mandate

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<sup>\*</sup> Research Professor, Health Law and Policy Institute, Assistant Visiting Professor, University of Houston Law Center, and Visiting Professor, Institute for the Medical Humanities, University of Texas Medical Branch. The author is grateful to the Institute for the Medical Humanities for its generous support during her appointment as a Visiting Scholar at the Institute, during which time the article was written, and to Bill Winslade, Kirk Smith and Lars Cisek for their useful comments and support.

<sup>1</sup> *See infra* note 20 and associated text.

<sup>2</sup> *See infra* notes 25-26 and associated text.

<sup>3</sup> *See infra* note 67 and associated text.

to care for patients without ability to pay.<sup>4</sup> They chiefly care for patients with public insurance sources, usually Medicaid and Medicare, and the uninsured. The transfer of uninsured patients to public EDs went on for years prior to EMTALA's passage.<sup>5</sup> Nevertheless, the practice may have increased in the early 1980s<sup>6</sup> due at least in part to new payment limits on federal and state health coverage programs.<sup>7</sup> Faced with reduced Medicare reimbursements in relation to costs, particularly for ED care, private hospitals sought to treat fewer public-pay and uninsured patients in their EDs.<sup>8</sup>

In 1984 and 1985, the press seized upon the issue. Numerous articles were published providing anecdotal evidence of patient dumping.<sup>9</sup> Many of these articles described incidents in which

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<sup>4</sup> See, e.g., Phyllis E. Bernard, *Privatization of Rural Public Hospitals: Implications for Access and Indigent Care*, 47 MERCER L. REV. 991, 999 (1996); JENNIFER HUANG ET AL., AMERICA'S PUBLIC HOSPITALS AND HEALTH SYSTEMS: 2003 1 (2003), available at [http://www.naph.org/Content/ContentGroups/Publications1/NAPH\\_2003\\_Hospital\\_Characteristics\\_Survey.pdf](http://www.naph.org/Content/ContentGroups/Publications1/NAPH_2003_Hospital_Characteristics_Survey.pdf) (last visited Feb. 14, 2006).

<sup>5</sup> Cases document the existence of the practice, although how widespread it was appears to have been largely unquantified prior to the 1980s. See, e.g., *Le Jeune Road Hosp., Inc. v. Watson*, 171 So. 2d 202 (Fla. 1965); *New Biloxi v. Frazier*, 146 So. 2d 882 (Miss. 1962); *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 175 (Del. 1961); *O'Neil v. Montefiore Hosp.*, 202 N.Y.S.2d 436 (1960). See also, e.g., Helen Creighton, *Your Legal Risks in Emergency Care*, 8 NURSING 52 (1978); J. F. Horty, *Emergency Care—or Lack of It—Can Make a General Hospital Liable*, 96 MODERN HOSPITAL 103 (Mar. 1961).

<sup>6</sup> See, e.g., R.L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986).

<sup>7</sup> See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (codified in relevant part at 42 U.S.C. § 1395ww (2003)).

<sup>8</sup> For information and further citations concerning the increased financial risk that hospitals had to absorb following the implementation of the DRG system, see Eric Munoz et al., *Source of Admission and Cost: Public Hospitals Face Financial Risk*, 76 AM. J. PUB. HEALTH 696 (1986).

<sup>9</sup> See, e.g., Peter Alshire, *Indigent Healthcare Issue Takes Spotlight*, OAKLAND TRIBUNE, Dec. 29, 1985; Paul Saltzman, *Court Says Hospital Must Accept Indigent*, MIAMI HERALD, Sept. 20, 1985, at A1; Richard Saltus, *Activists Call for Laws Insuring Hospital Care of Indigents*, BOSTON GLOBE, July 7, 1985, at B5; Bard Lindeman, *Some Hospitals Turn Away Uninsured Patients*, MIAMI HERALD, Apr. 22, 1985, at D2; Abigail Trafford, *Hospitals: A Sick*

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uninsured patients suffered severe injuries or died because of lengthy delays due to the shuffling from hospital to hospital before finally ending up at a public ED.<sup>10</sup> At the same time, two studies were published that helped quantify both the phenomenon and effects of patient dumping in two urban areas.<sup>11</sup> Because of the perception of a significant problem, Congress enacted EMTALA in 1986.

Since its enactment, particularly in the years since the Centers for Medicare and Medicaid Services (CMS) began enforcing it more vigorously, EMTALA has been controversial among physicians, hospitals and healthcare attorneys. Numerous articles discuss the sources of controversy, most notably, the interpretation of related regulations and case law, and the role that EMTALA has allegedly played in contributing to ED overcrowding and closures since its enactment.<sup>12</sup>

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*Industry*, U.S. NEWS & WORLD REP., Mar. 18, 1985, at 39; Vicky Cahan, *When the Patient Can't Pay the Medical Bill*, BUSINESS WEEK, Feb. 18, 1985, at 59; Richard A. Knox, *Health Policy: Some Local Hospitals Dump the Uninsured*, BOSTON GLOBE, Feb. 6, 1984; Elizabeth Fee, *The Second Sickness: Contradictions of Capitalist Healthcare*, MONTHLY REV., Feb. 1, 1984, at 49; Marc Fisher, *Mayor: Hospital "Dumped" AIDS Victim*, MIAMI HERALD, Oct. 9, 1983, at A1.

<sup>10</sup> See, e.g., 131 CONG. REC. E942 (daily ed. Mar. 19, 1985) (statement of Rep. Garcia, detailing an article published in the *Wall Street Journal*); Knox, *supra* note 9.

<sup>11</sup> David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 495 (1984); R.L. Schiff et al., *supra* note 6.

<sup>12</sup> See, e.g., Sarah Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J. L. MED. & ETHICS 590 (2003); Robert A. Wanerman, *The EMTALA Paradox*, 40 ANN. EMERG. MED. 464 (2002); Loren A. Johnson et al., *The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem*, 37 ANN. EMERG. MED. 495 (2001); Wendy W. Bera, *Preventing "Patient Dumping: The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA*, 38 HOUS. L. REV. 616 (1999); David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998); Arthur L. Kellerman et al., *Access of Medicaid Recipients to Outpatient Care*, 330 N. ENG. J. MED. 1426 (1994); Diana K. Falstrom, *Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure for Patient Dumping*, 19 N. KY. L. REV. 365 (1992).

Less discussed, however, is EMTALA's status as a throwback to a previous era of charity care, and its role within the larger U.S. healthcare system. By mandating potentially uncompensated care, EMTALA effectively represents a partial federal codification of what was previously a voluntary undertaking by physicians and hospitals, made financially feasible through what used to be a relatively flexible and multi-tiered reimbursement system.<sup>13</sup> EMTALA, which has been called the "safety net of the safety net,"<sup>14</sup> became necessary because of a number of diverse factors that experienced significant changes in the twenty years or so preceding its enactment. These factors include radical changes in healthcare organization and finance following the enactment of Medicare and Medicaid in 1965,<sup>15</sup> governmental action concerning issues of race and poverty in the provision of healthcare,<sup>16</sup> and, most notably, a sharp and steady increase in the number of uninsured Americans.<sup>17</sup> EMTALA exists, in effect, to help support our private and non-universal system of healthcare, based on a notion of charity care that is far more tenuous in today's healthcare market than at the time of the statute's enactment.<sup>18</sup> Yet its support can no longer secure this country's continued failure to move to a system of universal access, even in conjunction with public healthcare programs.

Part I of this Article briefly discusses EMTALA's salient provisions. Part II examines the history of emergency care and changes in healthcare organization and finance affecting the provision of charity care—topics which are significant in unraveling the alleged effects EMTALA has had on the healthcare system. Part III examines policy issues raised by EMTALA within our present system of health insurance and healthcare organization

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<sup>13</sup> See *infra* Section III.A.

<sup>14</sup> Peter Cunningham & Jessica May, CTR. FOR STUDYING HEALTHCARE CHANGE, ISSUE BRIEF NO. 70: *Insured Americans Drive Surge in Emergency Department Visits*, available at <http://hschange.org/CONTENT/613> (last visited May 8, 2006).

<sup>15</sup> See *infra* notes 61-64 and associated text.

<sup>16</sup> See *infra* notes 73-80 and associated text.

<sup>17</sup> See *infra* notes 69-72 and associated text.

<sup>18</sup> See *infra* Section III.A.

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and finance. It reaches two conclusions. First, EMTALA, while a poor and archaic fit with our present system of healthcare delivery and finance, in fact has helped to preserve our largely private, voluntary system of healthcare. Second, EMTALA is not likely a major culprit in the financial woes of private hospitals and in ED overcrowding and closures. Rather, greater pressures on the healthcare system, pressures that EMTALA itself was meant in part to address, are to blame. To solve these problems, U.S. policy regarding the nature and provision of healthcare itself must be reformed. While there are a number of minor measures concerning issues of finance and capacity that could be implemented to improve access to emergency care without requiring significant changes, a real solution may require greater public financing and control of health insurance, and the creation of incentives to expand emergency capacity in at least some settings.

#### I. EMTALA'S PROVISIONS

Congress enacted EMTALA in response to a growing public perception of patient dumping in the early and mid-1980s. EMTALA applies to all hospitals with an ED that have a federal contract to provide Medicare services.<sup>19</sup> As virtually all hospitals with an ED also have a contract with the federal government to provide services to Medicare enrollees, the statute therefore applies to treatment at virtually all EDs. The statute requires EDs at all covered hospitals to screen all ED patients who request treatment (or for whom treatment is requested by another party) for an "emergency medical condition."<sup>20</sup> An emergency medical condition exists when the absence of immediate medical attention may be expected to result in the patient's death or serious harm to either a major bodily function or body part.<sup>21</sup>

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<sup>19</sup> Emergency Medical Treatment and Active Labor Act (EMTALA) Pub. L. No. 99-272, Title IX, § 9121, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. 1992)).

<sup>20</sup> *See* 42 U.S.C. § 1395dd(a). All hospitals that accept Medicare as payment are included under the statute.

<sup>21</sup> 42 U.S.C. § 1395dd(e)(1); *see also* 42 C.F.R. § 489.24(b) (West 2005). It also pertains to a woman in labor, where there is not enough time to affect a safe

When screening the patient, the ED staff must adhere to the same policy it uses in screening any other patient.<sup>22</sup> For example, it may not lawfully screen an unconscious homeless man differently than it would anyone else with similar symptoms. Nor may the ED lawfully delay screening to inquire about the individual's ability to pay.<sup>23</sup> If the medical personnel who screen the patient find no emergency medical condition, then EMTALA imposes no obligation upon the ED or its staff to provide the patient with any treatment.<sup>24</sup>

However, if the patient is found to have an emergency medical condition, the ED staff must "stabilize" his condition before transferring or discharging him.<sup>25</sup> Stabilization entails taking

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transfer to another hospital prior to delivery, or where such a transfer would place the life or safety of the woman or fetus in jeopardy.

<sup>22</sup> *Id.* EMTALA does not prescribe any national standard for evaluation or treatment. *See, e.g.*, *Baber v. Hospital Corp. of America*, 977 F.2d 872, 878, 880 (4th Cir. 1992) (holding that "EMTALA only requires hospitals to apply their standard screening procedure . . . uniformly to all patients" and noting with respect to screening examinations that Congress "could have clearly specified a national standard," had it wished to do so).

<sup>23</sup> 42 U.S.C. § 1395dd(h).

<sup>24</sup> 42 C.F.R. § 489.24(c) (West 2005)

If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

*Id.* Note additionally that concern regarding medical malpractice issues, which are wholly separate from EMTALA, may nevertheless counsel that ED staff provide a patient with instructions to consult a physician regarding any non-emergent condition that the screening examination may turn up, or with other orders for treatment or follow-up care.

<sup>25</sup> EMTALA only requires an ED to provide care sufficient to stabilize the patient. *See, e.g.*, 42 U.S.C. § 1395dd(b)(1)(A) (providing that a hospital must provide, "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition"). In the case of a woman in labor, "stabilization" means delivery of both the fetus and the placenta. 42 U.S.C. § 1395dd(e)(3)(A).

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whatever medical measures are available and necessary to ensure that the individual's medical condition will not materially deteriorate during or as a result of transfer from the facility.<sup>26</sup> A hospital may forego stabilization and instead transfer an unstabilized patient with an emergency medical condition only if the patient herself requests a transfer in writing or a physician or other authorized medical personnel certifies in writing that the benefits to the patient of treatment elsewhere outweigh the risks of transfer.<sup>27</sup>

Physicians and hospitals that violate EMTALA's provisions are liable for up to \$50,000 in civil penalties per violation by the federal Office of the Inspector General (OIG).<sup>28</sup> In egregious cases, the Center for Medicare and Medicaid Services (CMS) may also terminate offenders from participation in Medicare, although this rarely happens.<sup>29</sup> The statute also provides for a private right of action, so a patient harmed by an EMTALA violation may also sue a participating hospital.<sup>30</sup>

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<sup>26</sup> 42 U.S.C. § 1395dd(e)(3)(A).

A patient is considered stable for discharge (vs. for transfer from one facility to a second facility) when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up, treatment, or both, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions.

*Id.* Loren A. Johnson et al., *The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem*, 37 ANN. EMERGENCY MED. 495, 495–499 (May 2001) (quoting HCFA, EMTALA STATE OPERATIONS MANUAL Tag A 407 (1998)).

<sup>27</sup> 42 U.S.C. § 1395dd(c)(1)(A). In the latter case, the hospital must provide appropriate transportation, and must include all relevant medical records.

<sup>28</sup> *See* 42 U.S.C. § 1395dd(d)(1).

<sup>29</sup> *Id.* Between 1986 and 2001, only four hospitals have been terminated from Medicare for EMTALA violations, and two of those four were later reinstated. *See* U.S. GEN. ACCOUNTING OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3 (June 2001), available at <http://www.gao.gov/new.items/d01747.pdf> (last visited Jan. 26, 2006) [hereinafter GAO, EMERGENCY CARE].

<sup>30</sup> 42 U.S.C. § 1395dd(d)(2)(A). This private right of action does not include the right to sue physicians or other healthcare providers for alleged



## II. EMERGENCY CARE IN HISTORICAL, SOCIAL AND ECONOMIC CONTEXT

To understand the issues posed by EMTALA, some background is necessary. First, a brief history of the provision of emergency medicine in this country is necessary to better evaluate the origins of some of the problems often blamed on EMTALA. Second, it is necessary to look briefly at changes in healthcare organization and finance that have allowed providers increasingly less leeway to shift costs from the uninsured and poorly insured to the well insured and wealthy. The actual amount of uncompensated care provided by EDs at most voluntary and for-profit hospitals is small, even post-EMTALA.<sup>31</sup> Nevertheless, the perception of providers is that uncompensated care, presumably to the poor, is ruining their hospitals. This perception is likely caused in part because of restrictions on providers' ability to cost-shift in response to the federal mandate to provide care, even if uncompensated, to people with unstable emergency conditions who present at the ED.<sup>32</sup> Thus, EMTALA's "unfunded mandate" becomes a target for providers' ire in an increasingly pinched system.

### A. *A Brief History of Emergency Care*

At the end of the nineteenth century, EDs as we know them today did not exist. The majority of healthcare was provided at that time by physicians, most of whom delivered care via house-calls.<sup>33</sup> As the quality and efficacy of allopathic medical care improved and patients increasingly sought allopathic medical care, physicians made fewer house-calls, instead requiring their patients to travel to them.<sup>34</sup> Meanwhile, with the rise of aseptic technique

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EMTALA violations. *See id.*

<sup>31</sup> *See infra* note 43 and associated text.

<sup>32</sup> *See infra* Section II.B.

<sup>33</sup> *See, e.g.*, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 68–71 (1982).

<sup>34</sup> *Id.* at 75-77.

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and anesthesia, surgical care grew increasingly common.<sup>35</sup> The need for hospitals as a locus of surgical practice and patient recovery grew correspondingly.

For much of the twentieth century, there were two primary types of hospitals: public and private nonprofit.<sup>36</sup> Public hospitals are institutions funded by the local government for the purpose of providing healthcare for impoverished and underserved county residents.<sup>37</sup> Such hospitals, usually based in larger metropolitan areas, have provided the lion's share of care over the last century to the indigent and, in more recent decades, the uninsured. Public hospitals continue to form an essential piece of the nation's safety net. In 2003, 60% of patients receiving care at public hospitals nationwide were either uninsured or had Medicaid as their source of insurance, and 43% of net public hospital revenues came from these two payer sources.<sup>38</sup>

Private nonprofit hospitals, on the other hand, both could, and today still do, discriminate amongst potential patients, whether (formerly) on the basis of race or ethnicity, or (both formerly and presently) on the perceived or actual ability to pay.<sup>39</sup> In 2004, 61% of all community hospitals in the United States were private nonprofit hospitals, each operating in different environments and possessing different missions.<sup>40</sup> Generally, they provide care to far

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<sup>35</sup> *Id.* at 156–57.

<sup>36</sup> ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 8-10 (1989). For-profit hospitals existed, but treated a relatively small number of patients. *Id.* at 20.

<sup>37</sup> See HUANG ET AL., *supra* note 4, at 1-2, 10.

<sup>38</sup> *Id.* at 8, 12. Note that gross charges for Medicaid accounted for 32 percent of gross public hospital charges in 2003, whereas Medicaid accounted for 37 percent of net public hospital revenues in the same year. *Id.* at 12. The disparity is due to the subsidies that public hospitals, among others, receive from Medicaid through disproportionate share hospital (DSH) payments. DSH payments complicate comparisons with private hospital revenues, short of receiving more precise and detailed data.

<sup>39</sup> STEVENS, *supra* note 36, at 137-38, 310.

<sup>40</sup> See *Fast Facts from AHA Hospital Statistics* (2005), AMERICAN HOSPITAL ASS'N, available at [http://www.aha.org/aha/resource\\_center/fastfacts/fast\\_facts\\_US\\_hospitals.html](http://www.aha.org/aha/resource_center/fastfacts/fast_facts_US_hospitals.html) (last visited Feb. 14, 2006).

fewer uninsured and Medicaid patients than do public hospitals.<sup>41</sup> The American Hospital Association's data for 2003 indicates that only 16% of respondent hospitals' gross revenues (including both nonprofit and for-profit private hospitals) came from Medicaid or uninsured patients, with the remainder coming from privately insured and Medicare patients.<sup>42</sup> In contrast to the public hospitals' rate of 21%, private hospitals provided uncompensated care equivalent only to about 5% of their gross revenues in 2003.<sup>43</sup>

Prior to EMTALA, a minority of states already mandated that hospitals provide care in genuine emergencies regardless of a patient's ability to pay. In some states, this rule was set by statute. In 1927, Illinois was the first state to enact a law providing that all licensed hospitals must provide emergency medical care to those who present with an emergent condition.<sup>44</sup> A minority of other states followed suit over the next fifty years.<sup>45</sup> Where actual legislation did not exist, the common law sometimes filled the gap. In *Wilmington General Hospital v. Manlove*, the Delaware Supreme Court held that where a hospital emergency room refused to treat an ill child who died shortly thereafter, a hospital could be liable for refusing care in an "unmistakable emergency."<sup>46</sup> A

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<sup>41</sup> Voluntary hospitals in academic teaching centers do provide more uncompensated care, on average, than other voluntary hospitals; however, they still provide far less than public hospitals. See, e.g., Joel S. Weissman et al., *Hospitals' Care of Uninsured Patients During the 1990s: The Relation of Teaching Status and Managed Care to Changes in Market Share and Market Concentration*, 40 INQUIRY 84, 89 (2003).

<sup>42</sup> *The Fragile State of Hospital Finances*, AMERICAN HOSPITAL ASS'N 6, available at <http://www.ahapolicyforum.org/ahapolicyforum/resources/content/FragileStateChartPack.pdf> (last visited Feb. 24, 2006).

<sup>43</sup> See HUANG ET AL., *supra* note 4, at 1; see also Joel S. Weissman et al., *supra* note 41, at 89 (providing earlier data). Notably, private hospitals serving as a "flagship" hospital for a medical school provided more uncompensated care than the norm among private hospitals (6.7 percent, as compared with less than 5 percent for other private hospitals). *Id.*

<sup>44</sup> MARGUERITE R. MANCINI & ALICE T. GALE, EMERGENCY CARE AND THE LAW 50 (Aspen 1981). *But see* Schiff et al., *supra* note 6 (demonstrating that, at least in one part of Illinois, the statute apparently had little effect).

<sup>45</sup> MANCINI & GALE, *supra* note 44, at 50.

<sup>46</sup> 54 Del. 15, 23 (1961).

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number of other jurisdictions followed a version of this rule in ensuing years.<sup>47</sup>

With the rise of surgical specialties and hospital-based care, and a correlating decline in house-calls and after-hours care provided by individual physicians, patients increasingly sought care for urgent and emergency medical conditions at hospitals. Additionally, the development of modern, dedicated emergency rooms, staffed around the clock, at hospitals beginning in the 1960s further encouraged this trend.<sup>48</sup> These factors helped give rise to the use of EDs as places in which to obtain routine ambulatory medical care during off-hours, when both the patient and her regular physician were off work.<sup>49</sup> Correspondingly, the rise in ED use has outstripped the population growth for five decades now – significantly longer than EMTALA’s existence.<sup>50</sup>

*B. Changes in Reimbursement Affecting Uncompensated Care*

Over the past five decades, healthcare finance underwent several dramatic changes that affected the provision of emergency care. First, by the mid-1950s, many Americans had obtained private employment-based health insurance to cover hospital and physician care rather than paying out of pocket.<sup>51</sup> These policies often paid for emergency medical care as part of hospital care,

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<sup>47</sup> See, e.g., *Guerrero v. Copper Queen Hosp.*, 112 Ariz. 104, 106 (1975); *Stanturf v. Sipes*, 447 S.W.2d 558 (Mo. 1969); *Le Juene Road Hosp., Inc. v. Watson*, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965); *Barcia v. Society of New York Hosp.*, 241 N.Y.S.2d 373 (1963).

<sup>48</sup> See, e.g., Daniel F. Danzl & Benson S. Munger, *History of Academic Emergency Medicine*, SOC’Y FOR ACAD. EMERGENCY MED., available at <http://www.saem.org/publicat/chap1.htm> (last visited May 8, 2006).

<sup>49</sup> See, e.g., Howard R. Kelman & Dorothy S. Lane, *Use of the Hospital Emergency Room in Relation to the Use of Private Physicians*, 66 AM. J. PUB. HEALTH 1189, 1191 (1976) (finding that 51 percent of suburban individuals seeking care in EDs had a regular primary care physician (PCP), but came to the ED because the physician was not available at the time that care was needed, and that a further 15 percent were referred by their PCP because they needed services that the PCP did not offer).

<sup>50</sup> See *infra* note 114 and associated text.

<sup>51</sup> See STARR, *supra* note 33, at 338.

making a visit to the ED financially feasible as well as convenient.<sup>52</sup> Hospitals and physicians were largely free to determine the amount they charged their patients.<sup>53</sup> This permitted them to “overcharge” wealthy patients and charge a more modest fee to middle-income patients in order to provide a reduced fee or charity care for their most impoverished patients.<sup>54</sup> As long as hospitals were able to attract a sufficiently high proportion of moneyed patients, they could afford to provide a certain amount of charity care to the indigent.

Even with the ability to charge patients different prices according to ability to pay, private hospitals, even voluntary hospitals, provided only a small amount of charity care in the early 1900s.<sup>55</sup> Still, such charity care, which totaled the equivalent of 9 to 15% of gross revenues in value according to certain local estimates, was much higher than that found nationwide by the latter part of the century. In 1980, one study found that the value of free or uncompensated care totaled the equivalent of less than 5% of the gross receipts of voluntary hospitals for that year, as compared with about 20% for public hospitals.<sup>56</sup> Although studies

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<sup>52</sup> Cf. Danzl & Munger, *supra* note 48 (observing that health insurance in its early decades, as in the Blue Cross model, covered hospital care rather than physician office visits, and attributing this fact as a factor in the dramatic rise in ED use from the 1950s through 1970).

<sup>53</sup> See, e.g., STARR, *supra* note 33, at 375–78.

<sup>54</sup> See, e.g., STEVENS, *supra* note 36, at 108.

<sup>55</sup> For example, in San Francisco in 1922, only 9 percent of the patient days in voluntary hospitals were provided free of charge; 77 percent were full pay and the remainder were paid in part. See STEVENS, *supra* note 36, at 107 (citing EMERSON & PHILIPS, HOSPITALS AND HEALTH AGENCIES OF SAN FRANCISCO 48 (1923)). In Illinois in 1917, 77 percent of patients paid the full fee, whereas 15 percent paid nothing and 9 percent paid only part of their charges. *Id.* at 32 (citing STATE OF ILLINOIS, REPORT OF THE HEALTH INSURANCE COMMISSION OF THE STATE OF ILLINOIS, 85, 87 (1919)).

<sup>56</sup> Drew E. Altman & Douglas H. Morgan, *The Role of State and Local Government in Health*, 2 HEALTH AFFAIRS 7, 13 (1983) (citing Jack Hadley et al., *Care for the Poor and Hospital Financial Status: Results of a 1980 Survey of Hospitals in Large Cities*, URBAN INSTITUTE WORKING PAPER NO. 144402 (1983)). See also Frank A. Sloan et al., *Identifying the Issues: A Statistical Profile*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 23 (Samuel H. Boyer et al., eds., 1986) (finding similar results). But note that some

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have shown slight fluctuations, the present value of uncompensated care for private hospitals (including for-profits) remains at the equivalent of about 4.5 to 5% of gross receipts.<sup>57</sup>

As a second significant change, Medicare and Medicaid, enacted in 1965, provided coverage to the elderly and the “deserving” poor—two groups that previously had often had limited access to healthcare.<sup>58</sup> As with private health insurance, Medicare and Medicaid afforded ED access, thus increasing the spectrum and number of individuals who could seek care at an ED and reasonably expect to obtain it.<sup>59</sup> Medicare further reimbursed at the rate charged by each individual provider.<sup>60</sup> One would expect that hospitals’ ability to provide emergency care to all comers would correspondingly rise with an increase in the pool of paying patients obtaining care on a fee-for-service basis. This is not, however, ultimately how Medicare, in particular, affected the provision of uncompensated care in EDs.

Rather, in 1983, facing skyrocketing medical costs, the federal government implemented the Medicare Prospective Payment System.<sup>61</sup> This system set Medicare’s compensation according to a complex system of reimbursement, based on diagnosis related groups (DRGs).<sup>62</sup> The inception of the DRG system was the beginning of the end of the prior system in which providers charged their patients differing amounts based in part on ability to pay, as it capped the upper end for charges. Medicare reimbursement fluctuated and in most years rose at a lower rate

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researchers in the Lewin Group, among others, observe that calculating provision of charity care can vary from state to state, so any national data should be taken with some skepticism. *See, e.g.*, Lawrence S. Lewin & Timothy J. Eckels, *Setting the Record Straight*, 318 *NEW ENG. J. MED.* (1988); Gary Claxton et al., *Public Policy Issues in Nonprofit Conversions: An Overview*, 16 *HEALTH AFFAIRS* 9, 15 (1997).

<sup>57</sup> *See supra* note 43 and associated text.

<sup>58</sup> *See, e.g.*, Theodore Marmor & Jonathan Oberlander, *Rethinking Medicare Reform*, 17 *HEALTH AFFAIRS* 52, 60 (1998).

<sup>59</sup> *See, e.g.*, 42 U.S.C. §§ 1395f(d)(1); 1395n(b)(1) (West 2005).

<sup>60</sup> *See, e.g.*, STARR, *supra* note 33, at 375.

<sup>61</sup> Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 (codified in relevant part at 42 U.S.C. § 1395ww).

<sup>62</sup> *See, e.g.*, 42 U.S.C. § 1395ww(a), (b) (West 2006).

than medical inflation generally.<sup>63</sup> With managed care's ascendance and a corresponding decline in fee-for-service medicine, insurers, meanwhile, often contracted with providers to reimburse at a certain percentage above the Medicare reimbursement.<sup>64</sup> As a result, providers lost a degree of their prior ability to engage in fee-shifting. Compounding this problem, the federal government implemented rules requiring that providers refrain from discounting a significant percentage of their non-Medicare business, and penalized providers for discounting or writing off the patient-provided portion of their Medicare fees if they failed to provide a corresponding discount on the government's portion of the fee.<sup>65</sup> While both issues have subsequently been clarified or revised to give providers greater leeway in providing discounts to patients with less ability to pay, they arguably contributed to the chilling effect Medicare generally had on fee shifting.<sup>66</sup> With less latitude to shift fees, providers had

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<sup>63</sup> See *National Health Expenditures Web Tables*, Table 13, CTR. FOR MEDICARE AND MEDICAID SERVICES (CMS), (2006), available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf> (last visited Feb. 14, 2006).

<sup>64</sup> See, e.g., Thomas L. Gift et al., *Is Healthy Competition Healthy? New Evidence of the Impact of Hospital Competition*, 39 *INQUIRY* 45, 53 (2002).

<sup>65</sup> See 42 CFR § 1001.701(a)(1).

<sup>66</sup> While CMS has issued proposed regulations clarifying that providers may offer reduced or free care to uninsured or underinsured patients, it has not yet finalized them. See, e.g., Medicare and Federal Healthcare Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53939, 53941 (proposed Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001). Nevertheless, it issued a notice in 2005, instructing providers that:

No OIG [Office of the Inspector General] authority, including the Federal anti-kickback statute, prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. In addition, the OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients under the permissive exclusion authority at section 1128(b)(6)(A) of the Act.

OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858-01, 4872-73 (Jan. 31, 2005). Providers may therefore offer free or reduced-fee care to patients who are uninsured or underinsured without fear of

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fewer incentives to give free or reduced-cost care to patients, whether in the ED or elsewhere.

### III. POLICY ISSUES INVOLVING EMTALA: ACCESS TO CARE AND OVERCROWDING

EMTALA was enacted in the midst of significant changes in the organization and financing of healthcare and health insurance. At the time, charity care was waning while, simultaneously, the need for such care was rising. Meanwhile, medicine as a large and rapidly growing business was on the upswing. Yet EMTALA, as we shall see, harkens to an older era, one in which medical altruism arguably played a stronger role than it does today. This contrast has contributed to medical, social, and economic discomfort with the Act, which in turn has led to the scapegoating of the Act as the cause of a variety of social and economic ills within healthcare.

EMTALA, contrary to conventional wisdom, does not appear to be a significant cause of any of these problems. Rather, as we shall see, EMTALA provides a lens through which other, more widespread issues with our healthcare system become magnified.

#### *A. EMTALA and Access to Healthcare*

Patient dumping, where it occurs, can be a serious problem for the health and safety of public-pay and uninsured patients. Congress clearly intended EMTALA to help ameliorate this problem. EMTALA was meant to provide an “adequate first response to a medical crisis” for all ED patients and to “send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”<sup>67</sup> The American public generally expects that everyone can at least receive emergency medical care when necessary,

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reprisal from CMS, whether through reduction of their “usual charges,” or through exclusion from Medicare. *Id.*

<sup>67</sup> 131 CONG. REC. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Bob Dole).



regardless of his or her ability to pay, as it literally can mean the difference between life and either sudden death or severe disability. EMTALA codified that expectation, based on the longstanding ethical duty of healthcare providers to give charity care. Yet it did so at a time when not only the need for charity care was increasing due to a rising lack of health insurance, but also physicians' and hospitals' abilities to provide such care without substantial economic pain was declining due to changes in reimbursement.

The ED provides ready medical and surgical assistance for those who lack a regular source of care. Both lack of health insurance and racial minority status independently correlate with a dearth in regular sources of care.<sup>68</sup> As recently as the 1970s, the vast majority of the American public had access to some form of health insurance, whether public or private. In 1970, approximately 94% of Americans under age sixty-five had at least partial coverage.<sup>69</sup> In the mid-1970s, however, this began to change as healthcare costs rose at double-digit rates. By 1992, 15% of the U.S. population was uninsured.<sup>70</sup> This percentage remained relatively static or rose throughout the 1990s and into the present century.<sup>71</sup> By 2004, 45.8 million Americans were uninsured, comprising 15.6% of the population.<sup>72</sup>

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<sup>68</sup> Marsha Lillie-Blanton & Catherine Hoffman, *The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Healthcare*, 24 HEALTH AFFAIRS 198 (2005).

<sup>69</sup> See *Evolution of Present Private Health Insurance Coverage*, 51 CONG. DIG. 34, 35 (1972).

<sup>70</sup> U.S. CENSUS BUREAU, *Historic Health Insurance Tables*, Table HI-1 (2004), available at <http://www.census.gov/hhes/www/hlthins/historic/hihist1.html> (last viewed Feb. 24, 2006).

<sup>71</sup> *Id.* While the percentage appears to drop starting in 1999, this is due to a change in how the uninsured were calculated in the 2000 census. See ROBERT J. MILLS, U.S. CENSUS BUREAU, *HEALTH INSURANCE COVERAGE: 2001*, 20 (2002), available at <http://www.census.gov/prod/2002pubs/p60-220.pdf> (last visited Feb. 9, 2006).

<sup>72</sup> CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2004*, 16 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf> (last visited Feb. 9, 2006).

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People of color are also more likely to be uninsured. While people of color comprised 34% of the U.S. population in 2003, they accounted for 52% of the uninsured.<sup>73</sup> A number of studies examining different populations in the U.S. have found a correlation between lack of a regular source of healthcare and increased ED use.<sup>74</sup>

Teasing apart the separate impact of race and perceived or actual economic status on the access and receipt of emergency care can be difficult.<sup>75</sup> The widespread integration of private hospitals in the late 1960s did not solve all the problems with respect to either racial or economic prejudice in the provision of health services.<sup>76</sup> Now, the problems are, as David Barton Smith notes, “subtler and more difficult to untangle from the economic imperatives faced by providers.”<sup>77</sup> The 1960s saw a rise in the number of cases brought against hospitals for failure to provide emergency medical care.<sup>78</sup> A number of studies have additionally

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<sup>73</sup> MILLS, *supra* note 71, at 199.

<sup>74</sup> See, e.g., David C. Brousseau et al., *Association Between Infant Continuity of Care and Pediatric Emergency Department Utilization*, 113 PEDIATRICS 738, 739-40 (2004); William G. Johnson & Mary E. Rimsza, *The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization*, 113 PEDIATRICS 483, 484 (2004); Roger A. Rosenblatt et al., *The Effect of the Doctor-Patient Relationship on Emergency Department Use Among the Elderly*, 90 AM. J. PUB. HEALTH 97, 98 (2000).

<sup>75</sup> See, e.g., David Mechanic, *Disadvantage, Inequality, and Social Policy*, 21 HEALTH AFFAIRS 48, 54 (2002).

<sup>76</sup> As recently as the 1950s, African-Americans, among certain other races, had few options for hospital care, other than in county hospitals and, where they existed, historically black hospitals. Following Medicare's implementation in 1966, President Lyndon Johnson launched a Medicare Title VI certification effort, in which hospitals were required to integrate in order to qualify for Medicare reimbursement. Economics won out over prejudice. According to David Barton Smith, “more than 1,000 hospitals quietly integrated their medical staffs, waiting rooms, and hospital floors in less than four months.” See David Barton Smith, *Racial and Ethnic Health Disparities and the Unfinished Health Agenda*, 24 HEALTH AFFAIRS 317, 319-20 (2004).

<sup>77</sup> DAVID BARTON SMITH, *HEALTHCARE DIVIDED* 335 (Univ. of Mich. Press, 1999).

<sup>78</sup> See, e.g., *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791 (Ky. App. 1978); *Fabian v. Matzko*, 344 A.2d 569 (Pa. Super. 1975); *Hill v. Ohio*

found both racial and class-related disparities in care provided to those patients who successfully obtained medical care in EDs.<sup>79</sup> Given the disproportionate ED use in minority communities—particularly in poor African American and Latino communities—intentional and unintentional discrimination historically has been and continues to be a real issue in the provision of emergency care.<sup>80</sup>

EMTALA has improved but not solved these problems. There exist numerous horror stories of physicians and hospitals that refused to evaluate or treat very sick patients due to a real or perceived lack of health insurance or other impermissible issues, even following the passage of the statute.<sup>81</sup> When properly

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Cty., 468 S.W.2d 306 (Ky. App. 1970); *Standurf v. Sipes*, 447 S.W.2d 558 (Mo. 1969); *Ruvio v. N. Broward Hosp. Dist.*, 186 So. 2d 45 (Fla. Dist. Ct. App. 1966). Note that the rise in published cases of course may not mirror a rise in actionable events, but rather may reflect other factors, such as increasing visibility of the issue or increased access to the courts for plaintiffs in such cases.

<sup>79</sup> See, e.g., Janice C. Blanchard et al., *Racial and Ethnic Disparities in Health: An Emergency Medicine Perspective*, 10 ACAD. EMERGENCY MED. 1289 (2003); Jeffrey J. Bazarian et al., *Ethnic and Racial Disparities in Emergency Department Care for Mild Traumatic Brain Injury*, 10 ACAD. EMERGENCY MED. 1209 (2003); Arvind Venkat, *The Impact of Race on the Acute Management of Chest Pain*, 10 ACAD. EMERGENCY MED. 1199 (2003).

<sup>80</sup> See, e.g., Patrick H. Tyrance et al., *Emergency Department Costs: No Emergency*, 87 AM. J. PUB. HEALTH 1866 (1996).

<sup>81</sup> See, e.g., Mark Taylor, *EMTALA Cases Slowing Down*, 34 MOD. HEALTHCARE 19 (July 26, 2004). To take just one example, in the late 1980s, a California physician turned away a Romani (gypsy) man at the ED who had likely just had a heart attack. In defense of his action, the physician claimed that when a Romani comes to the ED, scores of their family members also come, filling the waiting room, loitering, picking pockets and generally causing a ruckus. They also, the physician claimed, tend not to be insured. On the strength of his negative stereotypes about Roma, the physician told the man (and his numerous family members) to go to another hospital, several miles away. The man died en route to the second hospital. No charges were ever filed against either the physician or the hospital (although the physician recounted having to call security for protection, as the man's relatives later returned to the hospital with knives, seeking revenge). Interview with Anonymous Physician (1992). Note that the Supreme Court ruled that proof of improper motive (such as those evidenced in this example) is not necessary in order to make out an EMTALA

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enforced, EMTALA can help prevent such incidents from taking place, and punish them when they do occur.

EMTALA is admittedly direct, and thus, in a certain sense, intuitive. If the problem is conceived simply as a failure of physicians and hospitals to carry out their charitable duties with respect to the poor, then EMTALA accomplishes the task. According to the congressional record, it appears that Congress perceived the provision of emergency care to indigents as a professional or moral obligation on healthcare providers that some were shirking. The existence of such an obligation is nothing new. Physicians have had an ethical obligation since at least the Middle Ages to provide general charity care.<sup>82</sup> It was first formalized for allopathic physicians in the United States in the 1847 American Medical Association (AMA) Code of Ethics.<sup>83</sup> While the Code notes that “the office of physician can never be supported as an exclusively beneficent one,” it prohibits physicians from providing free care to the affluent, suggests that payment should be conditioned on the ability of the patient to pay, and states that physicians should “cheerfully and freely” provide free care to the indigent.<sup>84</sup> Drawing on this history, the House Committee Report on EMTALA remarked that it “want[ed] to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.”<sup>85</sup>

One could question whether EMTALA would be enacted again today, if nothing had been done in 1985 and if we were today faced with the same evidence and public opinion regarding the matter as we were in the 1980s. It is not merely a matter of the policy choices currently being made by Congress and the present federal Administration. Rather, it has more to do with the gradual shift this country has seen in its conception of healthcare and those who

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violation. *See* *Roberts v. Galen of Virginia*, 525 U.S. 249, 253 (1999).

<sup>82</sup> *See, e.g.*, Karen Geraghty, *The Obligation to Provide Charity Care*, in *PROFESSING MEDICINE* 57 (American Medical Ass’n eds., 2002).

<sup>83</sup> *Id.* at 57–58.

<sup>84</sup> American Medical Ass’n (AMA) Code of Medical Ethics, Ch. II, Art. V, § 9; Ch. III, Art. I, § 3 (May 1847).

<sup>85</sup> H.R. Rep. 99-241(I) (July 31, 1985).

provide care over the past five decades or so.

Healthcare has, in this country, always had a shared status as a commodity and as a public good. The 1847 AMA Code of Ethics demonstrates this tension: physicians, who rely for their livelihood upon payment for the services they provide, are nevertheless ethically obliged to provide charity care to those in need.<sup>86</sup> The balance between the two has shifted variously over the years. During the past five decades in particular, this balance has tilted far more towards the “commodity” end of the scale, although the conception of healthcare as a public good still exists.<sup>87</sup> As noted above, charity care has substantially waned in the face of significant alterations in physician and hospital reimbursement.<sup>88</sup> At the same time, federal and state governments are increasingly seeking to pull back from guaranteed rights to healthcare for certain members of the population.<sup>89</sup> Even the current AMA Code of Ethics no longer obligates physicians to provide free care to the indigent.<sup>90</sup> Nevertheless, some physicians do still provide charity care, and the United States still guarantees, at least for now, a certain amount of healthcare to particular classes of low-income, elderly, disabled or indigent individuals.

It is likely that concern for the indigent and those with public insurance was not the only force behind approval of EMTALA. Patients had been turned away from private EDs due to lack of insurance long before EMTALA was ever contemplated.<sup>91</sup> While

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<sup>86</sup> See AMA Code of Medical Ethics, Ch. II, Art. V, § 9; Ch. III, Art. I, § 3.

<sup>87</sup> See generally John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311 (1997); David M. Frankford, *Privatizing Healthcare: Economic Magic to Cure Legal Medicine*, 66 SO. CAL. L. REV. 1 (1992).

<sup>88</sup> See *supra* notes 61-66 and associated text.

<sup>89</sup> The increased use of Section 1115 waivers in Medicaid, particularly with respect to defined contribution plans such as that presently being implemented in Florida and considered elsewhere, forms one aspect of this phenomenon. See, e.g., John V. Jacobi, *Dangerous Times for Medicaid*, 33 J. L. MED. ETHICS 834, 838-41 (2005).

<sup>90</sup> Rather, it instead mandates that “a physician shall support access to medical care for all people,” without specifying the manner in which a physician should carry out that duty. See AMA Principles of Medical Ethics, IX (2001).

<sup>91</sup> See, e.g., Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 8 AM. J.

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many states had adopted laws prohibiting certain transfers or requiring EDs to provide a minimum of care to all comers, the majority of states had not yet done so by the time EMTALA was enacted.<sup>92</sup> The problem that came to a head in the 1980s was not merely that uninsured and publicly insured patients were unable to receive medical care in emergencies, and suffered serious injuries or death as a result. This indeed was true, and unquestionably concerned Congress.<sup>93</sup> However, there was another concern.

Patients who were turned away from private EDs were often redirected to EDs at public hospitals, or otherwise ultimately showed up there for treatment.<sup>94</sup> Public hospitals have a legal duty to provide care for the indigent, and traditionally serve Medicare and Medicaid patients, among others. The cost of care for uninsured and underinsured patients seen at public hospitals largely comes out of local, and to a lesser extent, state and federal coffers.<sup>95</sup> Congress, when debating the act, was arguably aware of this issue, despite the fact that it does not appear that Congress expressly considered any hard figures concerning the public cost of caring for these patients.<sup>96</sup> Congress was further aware that

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L. & MED. 561, 567 (1988) (noting that, under the common law of most states, hospitals were generally allowed to refuse to initiate care for a prospective patient, no matter how dire the person's need).

<sup>92</sup> See, e.g., H.R. Rep. 99-241, pt. 3, at 6 (discussing Pub. Law 99-272) (1986).

<sup>93</sup> 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy).

<sup>94</sup> See Schiff et al., *supra* note 6; Himmelstein et al., *supra* note 11.

<sup>95</sup> Unlike the local share, in particular, the federal share is indirect, and usually comes in the form of Disproportionate Share Hospital (DSH) payments. Note as well that, in 1983, Congress considered providing \$52 million to public hospitals to help cover emergency medical care expenses for indigent patients, but ultimately declined to do so. See H.R. Conf. Rept. 98-44 (discussing Pub. Law 98-8) (Mar. 21, 1983).

<sup>96</sup> See, e.g., 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger); 132 CONG. REC. E 177 (daily ed. Mar. 11, 1986) (statement of Rep. Stark). At least two senators expressly observed in their statements concerning the act that Medicare's prospective payment system, as well as changes geared towards instilling more competition in the healthcare market, would result in less fat in the system, and accordingly less charity care. 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statements of Senators

EMTALA was merely a stopgap measure, a way of ensuring that the growing millions of uninsured and publicly insured Americans were able to obtain care in a genuine medical emergency without requiring a complete overhaul of the American system of healthcare insurance and finance.<sup>97</sup> As such, EMTALA not only helped guarantee that the uninsured and publicly insured could receive care in an emergency, but also that the cost of providing such care was borne by both the private and public sectors.

*B. EMTALA, ED Overcrowding and Financial Constraints*

Some physicians and other commentators allege that EMTALA has led to a sharp increase in “inappropriate” ED use by the uninsured and others. Since even the indigent must at least be given a medical screening examination if they present at an ED with a medical complaint, the conventional wisdom is that the indigent are to blame for problems with ED overuse and insolvency.<sup>98</sup> One commentator notes that,

Since EMTALA was enacted, emergency department use has surged from 85 million visits per year to almost 110 million visits per year, while more than 550 hospitals and 1,100 EDs closed, as did many trauma centers, maternity wards, and tertiary referral centers. Ninety percent of the remaining trauma centers are currently overwhelmed. Ninety percent of our larger hospitals have saturated their

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Durenberger and Proxmire).

<sup>97</sup> 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy).

[T]he environment of medical practice is changing dramatically. Hospitals are insecure about their futures. They are more reluctant than before to offer care for which they may not be compensated. At the same time, there are more people who have no health insurance and cannot pay for healthcare. These larger problems demand solutions. But we must not wait for complete solutions. It is imperative that all emergencies be treated appropriately today.

*Id.*

<sup>98</sup> See, e.g., Robert A. Bitterman, *Explaining the EMTALA Paradox*, 40 ANN. EMERGENCY MED. 470, 470-75 (2002).

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capacity for treating patients, primarily because of the lack of inpatient critical care beds and the nurses to staff them. Emergency medical services (EMS) diversion is rampant, most EDs are overcrowded, waiting times have increased 33%, and the number of individuals seeking emergency care who leave the ED before being seen has tripled in some areas of the country. Liability costs are soaring and malpractice insurance may not even be available in many states, such as Pennsylvania, West Virginia, Nevada, and Florida.<sup>99</sup>

If only EMTALA had not been enacted, so the conventional wisdom goes, these problems would either not exist, or would be substantially reduced.<sup>100</sup>

This perception has been widespread. In 1992, the U.S. Senate asked the General Accounting Office (GAO) to do a national study of the problem of overcrowding in hospital EDs.<sup>101</sup> It was an opinion study, measuring the beliefs of administrators and others within the emergency department only. The study found that those surveyed believed the problem to be caused largely by people seeking non-urgent care.<sup>102</sup> According to the data in the GAO

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<sup>99</sup> *Id.* (citations omitted).

<sup>100</sup> See, e.g., Robert Schafermeyer et al., *Political Issues in Emergency Medicine: The United States*, 16 EMERG. MED. AUSTRALASIA 183, 186-88 (2004); Bruce Siegel, *The Emergency Department: Rethinking the Safety Net for the Safety Net*, HEALTH AFFAIRS (Mar. 24, 2004), at [http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.146v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=siegel&fulltext=emta&andorexactfulltext=and&searchid=1140124486899\\_3572&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.146v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=siegel&fulltext=emta&andorexactfulltext=and&searchid=1140124486899_3572&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff) (last visited Feb. 16, 2006); V. George Velianoff, *Overcrowding and Diversion in the Emergency Department: The Healthcare Safety Net Unravels*, 37 NURSING CLINICS N. AM. 59 (2002).

<sup>101</sup> Lynne D. Richardson et al., *Emergency Department Crowding as a Health Policy Issue: Past Development, Future Directions*, 40 ANN. EMERGENCY MED. 388, 388-93 (2002) (citing U.S. GENERAL ACCOUNTING OFFICE, EMERGENCY DEPARTMENTS: UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE (Jan. 1993), available at <http://161.203.16.4/d36t11/148331.pdf> (last visited Nov. 19, 2002)) [hereinafter EMERGENCY DEPARTMENTS].

<sup>102</sup> *Id.*



report, 43% of all ED patients in 1990 had illnesses or injuries classified as non-urgent, particularly those seen in rural or small EDs.<sup>103</sup> Uninsured and Medicaid patients were believed to have significantly accounted for much of the growth in non-urgent ED use.<sup>104</sup> 88% of the patients with non-emergent conditions allegedly went to the ED even though they had other sources of healthcare available in the community.<sup>105</sup> Emergency departments cited a lack of a primary care physician as the reason for ED use in 42% of the non-urgent cases they saw in 1990.<sup>106</sup> If based on hard data, that would amount to fifteen million inappropriate ED visits in one year alone.<sup>107</sup> According to the report, 37% of ED patients who did not have a primary care provider in 1990 were either uninsured or on Medicaid.<sup>108</sup> Particularly in rural areas, patients with a primary care provider used EDs for after-hours non-urgent care.<sup>109</sup> Delays in care were most often seen in large urban EDs.<sup>110</sup>

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<sup>103</sup> *Id.* at 4, 20. Emergent conditions totaled 17 percent. The remaining 40 percent of cases constituted time-sensitive urgent conditions. *Id.* at 19.

<sup>104</sup> *Id.* at 19. Hospitals also cited an increase in the use of EDs by the elderly and an increase in serious illnesses and injuries as major factors in the increase in ED use. *Id.*

<sup>105</sup> *Id.* at 4–5.

<sup>106</sup> *Id.* at 21.

<sup>107</sup> *Id.* There were approximately 38 million ED visits in 1990. *Id.*

<sup>108</sup> EMERGENCY DEPARTMENTS, *supra* note 101, at 5.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 6. Note, on the other hand, that a recent study shows that, contrary to popular belief, ED overcrowding is caused in part by a significant increase in the rate of ED use by privately insured patients, not by uninsured patients. The rate of ED use for the uninsured rose at a rate comparable to Medicare patients—about 10 percent—when comparing the years 1996–1997 and 2000–2001. See Cunningham & May, *supra* note 14, at 2; see also, e.g., Stephen Zuckerman & Yu-Chu Shen, *Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?*, 42 MED. CARE 176 (Feb. 2004) (finding that “[t]he uninsured do not use more ED visits than the insured population as is sometimes argued”). ED use by those with private insurance increased, on the other hand, by 24 percent, even though the number of individuals who were privately insured increased only 4.1 percent over the same period. See Cunningham & May, *supra* note 14, at 2. Given that approximately two-thirds of the American public is covered by private health insurance, this indicates that the insured, rather than the

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Despite the 1992 GAO report's conclusion that ED overcrowding was largely due to an increase in non-urgent, uninsured patients, the actual cause of overcrowding appears to be multi-factorial, and may not in fact stem significantly from EMTALA's enactment at all. First, while the volume of ED patients has increased at a higher rate than has the U.S. population since EMTALA was enacted, this trend is nothing new. ED visits in 2000 through 2001 had increased 16.3% over visits in 1996 through 1997, whereas the total population had increased only 4.4% during the same time.<sup>111</sup> This parallels a trend observed earlier in the 1990s.<sup>112</sup> Yet if one looks back even further, one finds that this trend has a much longer history, predating EMTALA by at least a few decades.<sup>113</sup> According to at least one study, per capita ED visit rates rose 550% between 1955 and 1980, as compared with a 30% per capita increase in hospital inpatient use during the same time period and no appreciable per capita increase in physician office visits.<sup>114</sup> Additionally, a more recent study using national statistics from patient encounters rather than opinion data found that it is largely privately insured and Medicaid patients who are most responsible for the rising numbers.<sup>115</sup> This study found that patients with private health insurance or Medicare accounted for nearly 66% of the increase in ED visits between the study years of 1996 through 1997 and 2001 through 2002.<sup>116</sup> Population increase in general accounted for 25% of the increase in visits.<sup>117</sup> Visits by the uninsured, conversely, accounted for only

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uninsured, may significantly be contributing to ED overcrowding.

<sup>111</sup> See Cunningham & May, *supra* note 14, at 2. See also Wanerman, *supra* note 12.

<sup>112</sup> See, e.g., GAO, EMERGENCY CARE, *supra* note 29, at 9.

<sup>113</sup> See, e.g., Jerry E. Bishop, *Data Shows Decline in Annual Increase in Hospital Emergency Room Use*, WALL ST. J., Nov. 10, 1977, at X (reporting that ED use had increased only by 6 percent in 1976, as compared to average annual increases of 14 percent in the early 1970s).

<sup>114</sup> See, e.g., Kevin F. O'Grady, et al., *The Impact of Cost Sharing on Emergency Department Use*, 313 NEW ENG. J. MED. 484 (Aug. 22, 1985).

<sup>115</sup> See, e.g., Cunningham & May, *supra* note 14.

<sup>116</sup> *Id.* at 1.

<sup>117</sup> *Id.*

about 11% of the increase.<sup>118</sup> Emergent or urgent visits accounted for 47% of the visits during the study period, with semi-urgent, non-urgent and visits of unknown triage classification accounting for the remainder.<sup>119</sup>

Second, during the 1990s in particular, the total number of hospitals and EDs declined in an effort to cut costs and “improve efficiency”: e.g., promote a high census, or hospital occupancy rate.<sup>120</sup> Unoccupied beds earn no revenue and cost the hospital money to maintain staff and other operating costs. This is a particularly significant consideration for both nonprofit and for-profit hospitals, both of which compete in an often aggressive healthcare market, with hospital chains increasingly taking hold in the 1990s.<sup>121</sup> Accordingly, the number of inpatient beds declined in

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<sup>118</sup> *Id.* at 2.

<sup>119</sup> *Id.* at 3. Medicare patients are an exception here, with 57 percent of their visits in this study reported to be emergent. *Id.* Note that, because approximately 25 percent of all ED visits were of unknown triage classification, it is possible that more visits were in fact of an emergent or urgent nature than captured by the data. *See id.*

<sup>120</sup> Wanerman, *supra* note 12, at 461 (citing AMERICAN HOSPITAL ASS’N, *Emergency Departments - An Essential Access Point to Care*, TRENDWATCH (Mar. 2001)); AMERICAN HOSPITAL ASS’N (AHA), *CRACKS IN THE FOUNDATION: AVERTING A CRISIS IN AMERICA’S HOSPITALS 4* (Aug. 2002) [hereinafter *CRACKS IN THE FOUNDATION*]. The notion that EMTALA may be financially responsible for the hospital and ED closures cited above may be misplaced. At least one study indicates that, while they lost an average of \$84 per ED patient in 2002, California hospitals may have recouped those losses from the additional revenue they gained through hospital admissions from the ED, which averaged \$1,220 in profit per patient. *See* GLENN A. MELNICK ET AL., *CALIFORNIA’S EMERGENCY DEPARTMENTS: DO THEY CONTRIBUTE TO HOSPITAL PROFITABILITY?* 2 (2003), available at <http://www.chcf.org/topics/view.cfm?itemID=21192>. The study in question, however, did not evaluate public and private EDs separately, and also omitted Level I trauma centers, which are more likely to be in major urban centers and be part of a public hospital. As such, it may overstate the average revenues generated at hospitals that see predominantly more uninsured and public-pay patients, notwithstanding EMTALA.

<sup>121</sup> For more on the growth of hospital chains, see David Blumenthal & Joel S. Weissman, *Selling Teaching Hospitals to Investor-Owned Hospital Chains: Three Case Studies*, 19 *HEALTH AFFAIRS* 158, 158 (2000); Jack Needleman et al., *Hospital Conversion Trends*, 16 *HEALTH AFFAIRS* 187, 188-91 (1997).

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this period—as they have, in fact, historically in most years since hitting a peak of 1.7 million in 1965.<sup>122</sup> The decline in inpatient beds means fewer beds are available to acutely ill patients admitted through the ED, who must then wait in the ED for an inpatient bed to become available.<sup>123</sup> It is the acutely ill patients, moreover, who consume the largest share of ED time and resources.<sup>124</sup> The child with a mild upper respiratory ailment, on the other hand, ultimately requires far less of an ED provider's time, as well as ED bed space.

The percentage of severely ill patients seeking care through the ED is on the rise.<sup>125</sup> Fewer inpatient beds, in conjunction with increased ED use and increased severity in the types of conditions seen, can translate into longer waiting periods for those seeking semi-urgent or non-urgent care in EDs and more instances of EDs being put on “drive-by” status, in which they reach full capacity and can accept no further ambulance admissions.<sup>126</sup> The current nursing shortage in many areas compounds the problem, with an average nationwide vacancy rate of 13%.<sup>127</sup> Beds that are not staffed cannot be used.<sup>128</sup>

Third, several recent studies indicate that the increase in ED use in recent years is not predominantly due to visits by the uninsured seeking help for non-emergent conditions. Rather,

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<sup>122</sup> AHA, HOSPITAL STATISTICS 2 (2003).

<sup>123</sup> Robert W. Derlet, *Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity*, 39 ANN. EMERGENCY MED. 430, 431 (Apr. 2002). This is true, despite evidence that the number of ED beds increased in California, at least, during the 1990s, despite the decline in the total number of both hospitals and EDs in the state. *See, e.g.*, MELNICK, *supra* note 120; Susan Lambe et al., *Trends in the Use and Capacity of California's Emergency Departments, 1990 – 1999*, 39 ANN. EMERGENCY MED. 389, 393 (Apr. 2002).

<sup>124</sup> *See, e.g.*, Grant D. Innes et al., *Prospective Time Study Derivation of Emergency Physician Workload Predictors*, 7 CAN. J. EMERGENCY MED. 299, 303–04 (2005).

<sup>125</sup> *See, e.g.*, Robert W. Derlet & John R. Richards, *Emergency Department Overcrowding in Florida, New York and Texas*, 95 SO. MED. J. 848 (Aug. 2002).

<sup>126</sup> *See, e.g.*, Stephen Trzeciak & E. P. Rivers, *Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health*, 20 EMERGENCY MED. J. 402, 403–04 (2003).

<sup>127</sup> *See* CRACKS IN THE FOUNDATION, *supra* note 120, at 2.

<sup>128</sup> *See, e.g.*, Derlet, *supra* note 123, at 431.

insured patients are largely the ones using the ED in this way.<sup>129</sup> As the privately insured greatly outnumber the uninsured, the impact of the increase in privately insured patients is correspondingly larger.<sup>130</sup> Patients often seek non-emergent care at the ED because they cannot take time off of work during regular business hours to see their regular doctor or because they wish to see a doctor more quickly than they could if they scheduled an appointment with their regular provider.<sup>131</sup> With the loosening of curbs by managed care organizations, providers also feel increasingly free to refer patients to EDs.<sup>132</sup> These visits are predominantly non-urgent.<sup>133</sup>

For some who would like to lay blame for ED overcrowding, EMTALA is a convenient target. As noted above, Congress, by enacting EMTALA, imposed a requirement of charity care on private physicians and hospitals.<sup>134</sup> In the decades prior to EMTALA, charity care was a voluntary undertaking on the part of healthcare providers, one they performed as a matter of professional pride and custom.<sup>135</sup> By requiring private EDs to screen anyone who presents in the ED for an emergency medical

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<sup>129</sup> According to one study, while the number of uninsured seeking care at EDs did in fact increase between 1996 and 2001 by 10.3 percent, the percentage of privately insured patients seeking ED care increased far more significantly, by 24.3 percent during the same time period. Cunningham & May, *supra* note 14, at 3.

<sup>130</sup> In 2004, 15.7 percent of the U.S. population was uninsured, whereas 68.1 percent was privately insured (through employment or otherwise). DENAVAS-WALT, *supra* note 72, at 16.

<sup>131</sup> See, e.g., *id.* This is not a new phenomenon, either. See, e.g., Howard R. Kelman & Dorothy S. Lane, *Use of the Hospital Emergency Room in Relation to the Use of Private Physicians*, 66 AM. J. PUB. HEALTH 1189, 1190 (1976) (finding that 51 percent of suburban individuals seeking care in EDs had a regular primary care physician (PCP), but came to the ED because the physician was not available at the time that care was needed, and that a further 15 percent were referred by their PCP because they needed services that the PCP did not offer).

<sup>132</sup> Cunningham & May, *supra* note 14, at 3.

<sup>133</sup> *Id.*

<sup>134</sup> See *supra* Section III.A.

<sup>135</sup> See *id.*

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condition and to provide care to anyone with such a condition, regardless of their ability to pay, Congress turned a once-voluntary undertaking into a compulsory one. Without an internalization of Congress' mandate, providers, who might at one time willingly have provided at least some charity care through EDs, may resent their perceived loss of autonomy.<sup>136</sup> As such, they may be more likely to characterize matters such as poor revenues, loss of ED staff, and overcrowding as EMTALA's inevitable fallout.

Additionally, EMTALA unintentionally invites scapegoating of the poor and uninsured. The statute itself provides no method or funds for compensating providers for any free care they may render in its compliance. Medicare and Medicaid provide a small amount of compensation to help offset losses incurred through treating the indigent and providing emergency medical care to illegal immigrants, but the compensation is partial and indirect, and goes only to hospitals rather than to physicians or other individual providers.<sup>137</sup> Physicians and hospitals complain that the uninsured and Medicaid patients are deliberately taking advantage of EMTALA's directive to screen patients regardless of their ability to pay and that these patients clog EDs with routine medical problems.<sup>138</sup> Employers who provide health insurance to their employees complain that their premiums are sharply rising in part to subsidize healthcare provided to the growing ranks of the uninsured and publicly insured.<sup>139</sup> If one took such reports as true and looked no further, one might start to think that if only the uninsured and publicly insured would simply take responsibility for their own healthcare costs, ED overcrowding and healthcare premium inflation would ease, state and federal budget crises would cease, and the U.S. public could happily and responsibly enjoy the fruits of marvelous medical advances, many of which

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<sup>136</sup> See, e.g., Roger J. Lewis, *Academic Emergency Medicine and the "Tragedy of the Commons,"* 11 ACAD. EMERG. MED. 423 (2004).

<sup>137</sup> See, e.g., Medicare Prescription Drug Improvement and Modernization Act ("Medicare Modernization Act"), Pub. L. 108-173, Title X, § 1011, 117 Stat. 2432 (Dec. 8, 2003).

<sup>138</sup> See, e.g., Lewis, *supra* note 136.

<sup>139</sup> See, e.g., Stan Freeman, *Legislature, Employers Struggle with Insurance Issue*, THE REPUBLICAN, Feb. 5, 2006, at 31.

would be within the reach of most people's budgets.

Unfortunately, it is not that simple. Some once thought that the enactment of Medicare and Medicaid was the first incremental step towards universal coverage of all Americans.<sup>140</sup> As noted earlier, in 1970 nearly all Americans enjoyed some form of health coverage, largely through the private market.<sup>141</sup> Perhaps more Americans at that time had health insurance because they were more responsible and prudent than they are today; however, this is not likely the case. Consistent double-digit increases in healthcare costs and premiums, rather than a rapid lapse into irresponsibility, contributed to the erosion of private coverage.<sup>142</sup> By 1977, nearly 14% of the population was uninsured.<sup>143</sup> The year before EMTALA was enacted, over 17% of the U.S. public lacked health insurance.<sup>144</sup>

Congress, having just experienced two major attempts to enact some form of national health coverage in the prior decade, expected EMTALA to merely be a short-term fix, something to help tide the uninsured, underinsured and publicly insured through medical emergencies until some form of expansive or universal coverage had been enacted.<sup>145</sup> Congress understood that the poor and uninsured were not causing the problem of dumping, let alone the problems of medical inflation and health insurance. Rather, the poor and uninsured were the victims of these problems. No one in Congress debated their need for assistance.<sup>146</sup>

What would have happened had EMTALA not been enacted? Particularly in those states in which private EDs had no legal obligation to examine or treat uninsured and public-pay patients, it

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<sup>140</sup> See, e.g., ALAN DERICKSON, HEALTH SECURITY FOR ALL 136–37 (2005).

<sup>141</sup> See *supra* note 69.

<sup>142</sup> See *supra* notes 70–72 and associated text.

<sup>143</sup> Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 860 (1986).

<sup>144</sup> *Id.*

<sup>145</sup> See *supra* note 97 and associated text.

<sup>146</sup> See *supra* note 93 and associated text. It surely did not hurt that EMTALA required no new federal expenditures.

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is conceivable that the shifting of the indigent emergency caseload from private to public EDs would have increased whenever possible.<sup>147</sup> Indigent and other patients whom the hospital or staff found “undesirable” certainly would have suffered. Public hospitals also would have suffered, even more than they do under present conditions, as the shift could easily have led to paralyzing numbers of patients seeking care in their EDs.<sup>148</sup>

In such a case, one of three scenarios would likely have come about. In the first scenario, the local, state, and/or federal governments would have had to increase taxes significantly to cover the increased volume and concordant shortfalls in public hospital revenues. In the second scenario, many public hospitals would have had to close, depriving millions of uninsured and public-pay patients of a major source of healthcare. In the third scenario, most remaining states would likely have enacted a requirement that all hospitals with an ED must screen and, if necessary, treat all patients presenting to their EDs with an emergent condition. Either of the first two would likely have significantly destabilized our predominantly private healthcare system. The third might not have had significant efficacy, judging by problems that were known to exist even in states like Illinois, where such a law had been in effect for decades.<sup>149</sup>

If any of the hypotheses given above are correct, even in part, then EMTALA has acted as a safety valve for our present healthcare system. Dumping still occurs and public hospitals still treat a disproportionate number of uninsured and publicly insured individuals in their EDs. Nonetheless, the public hospital system continues to function and the uninsured and publicly insured usually can obtain emergency care. This is the case in part because private EDs and physicians are required to examine and, if necessary, treat patients who present in EDs without regard to their ability to pay, and the federal government can hold them

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<sup>147</sup> This may have been the result especially with the onset of the managed care revolution that further reduced private-pay revenue.

<sup>148</sup> Some would argue that we presently have reached such a situation. *See, e.g., Lewis, supra* note 136.

<sup>149</sup> *See supra* note 11 and associated text.



responsible for failing to do so.<sup>150</sup> In exchange, our private system of healthcare continues to exist, and private actors can continue to reap significant profits from it.<sup>151</sup>

#### IV. SUGGESTIONS FOR IMPROVEMENT

Entities can survive with inadequate revenues only for a limited period of time. It may be that, by requiring hospitals and physicians to evaluate and, if necessary, treat patients without regard to compensation, Congress assumed that these healthcare providers had sufficient revenues to pick up the added responsibility without going bankrupt. Alternatively, Congress may have deemed the loss of some healthcare providers to be acceptable in the face of the problem of patient-dumping and the desire to provide for the problem without taking any politically unpalatable step such as raising taxes, cutting services elsewhere, or taking up the issue of national health insurance yet again.<sup>152</sup> Whatever the rationale, however, the outcome is not reasonable. The federal government ought to directly assist all affected hospitals and healthcare providers in funding EMTALA, if EMTALA's obligations are to continue.<sup>153</sup> While EMTALA's goals should be supported, the federal government abdicated its responsibility by allocating the burden of financing the obligation

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<sup>150</sup> See *supra* Section I.

<sup>151</sup> That being said, little if any of the burden from EMTALA is felt by some of the most profitable sectors of the private healthcare industry: managed care entities and pharmaceutical companies. Regarding MCOs and EMTALA, see *infra* Section IV.

<sup>152</sup> For a discussion of the numerous attempts that have been made over the last century to enact universal health coverage in the United States, see DERICKSON, *supra* note 140.

<sup>153</sup> While DSH payments from the federal government provide funds to those hospitals serving a particularly large number of indigent patients, it does not provide for every hospital serving the indigent through ED or other services. Moreover, such payments do not provide for all or even most uncompensated care even for those hospitals that do receive such payments, and the Administration has threatened changes to the program that would effectively reduce DSH payments from their present levels. See, e.g., Jacobi, *supra* note 89.

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to screen and treat onto hospitals and ED physicians.<sup>154</sup>

The financial problems caused by EMTALA would further be eased if the federal government required health insurers to pay for emergency care using a “prudent layperson” standard.<sup>155</sup> Many managed care organizations (MCOs) require their subscribers to obtain preauthorization for treatment. Such MCOs may refuse to pay for emergency care in the absence of preauthorization, claiming that it was medically unnecessary, that no emergency condition existed, or that the hospital was out-of-network.<sup>156</sup> Because EMTALA prohibits EDs from delaying care to inquire about health insurance status, many assume that they cannot call a patient’s insurer to request preauthorization, for fear of running afoul of the statute.<sup>157</sup> Compounding this issue, CMS clearly provides that hospitals must delay discussing with a patient his or her ability to pay until after it begins stabilizing treatment.<sup>158</sup>

The problem is mitigated in part, in that nearly all states require health insurers to pay for emergency care, even where the patient did not receive preauthorization for treatment.<sup>159</sup> Most such laws provide that, as long as a “prudent layperson” might have thought the care to be urgent, given the patient’s symptoms, the insurer

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<sup>154</sup> The Medicare Prescription Drug, Improvement and Modernization Act of 2003 takes a step towards compensating emergency departments and their physicians for providing emergency care to undocumented aliens. From 2005–2008, the Act allocates \$250 million to be distributed according to a formula to compensate providers for treating undocumented aliens under EMTALA. *See supra* note 137. It remains to be seen whether DSH payments will undergo a corresponding reduction.

<sup>155</sup> If the federal government were to enact such a provision, it would circumvent the problem of ERISA preemption, unlike doing so at the state level. For further discussion *see, e.g.*, John D. Blum, *Overcoming Managed Care Regulatory Chaos Through a Restructured Federalism*, 11 HEALTH MATRIX 327, 334–35 (2001).

<sup>156</sup> *See, e.g.*, GAO EMERGENCY CARE, *supra* note 29, at 13.

<sup>157</sup> Recent changes to the regulations clarify that a physician or hospital may seek authorization, but *only* after a screening examination has occurred and stabilization has been initiated. *See* 42 C.F.R. § 489.24(d)(4)(ii) (West 2006).

<sup>158</sup> *See* 42 U.S.C. § 1395dd(e)(1); 42 C.F.R. § 489.24(d)(4).

<sup>159</sup> *See* Mark A. Hall, *The Impact and Enforcement of Prudent Layperson Laws*, 43 ANN. EMERGENCY MED. 558 (2004).

must pay. However, because of the preemption provisions of the Employee Retirement Income Security Act (ERISA), federal law preempts such laws in their application to self-funded health insurance plans sponsored by an employer.<sup>160</sup> This is a significant issue, because over half of all employees with employment-based health insurance are covered by a self-funded plan.<sup>161</sup> Federal regulation is therefore necessary in order to bring all privately insured individuals under the protection of the prudent layperson standard.<sup>162</sup>

As noted above, hospital capacity significantly affects the flow of patients through the ED and the number of inpatient beds has been declining for decades.<sup>163</sup> Patients who are admitted through the ED must remain in the ED until an inpatient bed is free.<sup>164</sup> If no inpatient bed is free, then the patient unnecessarily consumes both ED bed space and staff resources that could otherwise be used to attend another patient.<sup>165</sup> Yet, few hospitals will expand their capacity if they are not certain the beds will be filled with sufficient frequency to justify the expense.<sup>166</sup> Such certainty is in small supply at present, with declining public reimbursements and continued pressure from insurers to minimize inpatient stays.<sup>167</sup> Additionally, in those areas in which hospitals are having difficulty

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<sup>160</sup> See, e.g., Blum, *supra* note 155, at 334-35.

<sup>161</sup> See KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 109 (2005)

<sup>162</sup> Prudent layperson standards have been proposed in a variety of federal "patients' rights" bills proposed at the federal level but, to date, none have passed, and passage looks increasingly unlikely as the HMO subscription rate declines and other, more pressing matters intrude on Congress. For further discussion see, e.g., Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL. 1 (2005).

<sup>163</sup> See *supra* note 122 and associated text.

<sup>164</sup> See *supra* notes 123-24 and associated text.

<sup>165</sup> See *id.*

<sup>166</sup> See, e.g., *supra* notes 120-21 and associated text.

<sup>167</sup> For further discussion regarding declining public reimbursements, see Jonathan Weisman, *Tentative Agreement Reached on Budget*, WASH. POST, Dec. 18, 2005 (discussing the 2006 budget, which level-funded physicians under Medicare, narrowly averting a four percent cut that was supposed to be enacted).

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meeting their present staffing needs, they may be further unlikely to seek to expand their number of inpatient beds, each of which will require nursing and other staff support, not to mention further infrastructure. Persuading hospitals with overburdened EDs to expand their inpatient capacity would, absent new financial incentives, be a difficult sell at best.

It might be suggested that hospitals could be encouraged, likely through financial support or other means, to open and staff urgent care centers near or adjacent to their EDs.<sup>168</sup> These centers would specifically solicit patients in need of non-emergent care on a walk-in basis, and would be open during early morning, evening and weekend hours, as well as during regular business hours. Nevertheless, such centers could allow non-emergency patients to self-select a more appropriate option for care.<sup>169</sup>

This option would probably do little to solve ED woes, however. On the positive side of the ledger, it might reduce the patient volume in the ED waiting room, reduce wait times for non-urgent patients who self-selected to urgent care centers, and direct non-emergent care to more appropriate resources. But encouraging non-urgent patients to seek care elsewhere would likely not significantly speed the flow of patients through the ED, as truly emergent cases generally account for much of the hold up.<sup>170</sup> Additionally, private urgent care centers might cherry-pick the

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<sup>168</sup> Community health centers could also be opened for such purposes, with expanded hours. However, they can be hampered by problems with funding and insufficient staffing, among other issues. *See, e.g.,* Jessamy Taylor, *The Fundamentals of Community Health Centers*, NHPF BACKGROUND PAPER 17, 23 (Aug. 31, 2004), available at [www.communityclinics.org/files/848\\_file\\_NHPF\\_CHC\\_Fundamentals.pdf](http://www.communityclinics.org/files/848_file_NHPF_CHC_Fundamentals.pdf) (last visited Feb. 17, 2006).

<sup>169</sup> Patients who chose to be seen through the emergency room would of course need to be screened prior to being directed to the urgent care center, and patients who came to the urgent care center would need to be screened and, if necessary, stabilized pursuant to EMTALA's requirements. *See* CMS, MEDICARE PROGRAM: CLARIFYING POLICIES RELATED TO THE RESPONSIBILITIES OF MEDICARE-PARTICIPATING HOSPITALS IN TREATING INDIVIDUALS WITH EMERGENCY MEDICAL CONDITIONS 60-62 (2003), available at [new.cms.hhs.gov/EMTALA/Downloads/CMS-1063-F.pdf](http://new.cms.hhs.gov/EMTALA/Downloads/CMS-1063-F.pdf) (last visited Feb. 17, 2006).

<sup>170</sup> *See supra* notes 123-24 and associated text.

well-insured patients from the poorly-insured or uninsured ones, leaving the latter to obtain care from the ED. It makes little sense to seek to improve EDs' financial and administrative outlooks by draining better-paying patients from the ED.

While some of these proposals may offer small improvements, they do not touch the heart of the problem. EMTALA is necessary because our healthcare system leaves forty-five million Americans without coverage.<sup>171</sup> It is necessary because healthcare providers commonly obtain more generous reimbursement from private insurers than from Medicaid or Medicare.<sup>172</sup> It is necessary because our country has a long legacy of racial and economic discrimination that, while certainly improved from prior decades, still solidly exists today, albeit often in more subtle forms than in the past.<sup>173</sup>

An expansion of public health insurance to cover more of those who presently lack insurance would help matters, but only if provider reimbursements were also raised.<sup>174</sup> For a more complete solution, we must once again return to the prospect of some form of national health coverage. Only when everyone has the same baseline coverage for basic medical benefits, including emergency care, will we genuinely see the problem of dumping, and of blaming the poor and uninsured for our healthcare crises, dissipate.

Additionally, we may also need to reconsider the organization and control of our hospital system. Voluntary associations such as nonprofit hospitals are often conceived of as having a distinctly and positively American flavor, largely due to decades of lobbying by interested organizations.<sup>175</sup> Voluntary health entities "encourage[] the individual to enter into associations and organizations of his own choosing, encouraging the individual to provide health protection for his family through his own effort."<sup>176</sup> As such, they are "tied in not only with democracy and American

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<sup>171</sup> See DENAVAS-WALT, *supra* note 72, at 16.

<sup>172</sup> See *supra* note 64 and associated text.

<sup>173</sup> See *supra* notes 73-80 and associated text.

<sup>174</sup> See, e.g., R. E. Santerre, *The Inequity of Medicaid Reimbursement in the United States*, 1 APPLIED HEALTH ECON. & HEALTH POL'Y, 25, 31 (2002).

<sup>175</sup> See, e.g., STEVENS, *supra* note 36, at 224.

<sup>176</sup> *Id.*

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initiative, but with other traditional structures of American life.”<sup>177</sup> One probably could make similar claims now about for-profit institutions, as well.

Yet, if we want to continue supporting such systems, we need to understand that they come at a certain cost. With respect to emergency services, many EDs will continue to experience significant overcrowding and placement on drive-by status as hospital bed capacity continues to diminish because of concerns about profit maximization.<sup>178</sup> To help remain in the black, private hospitals must maintain high occupancy rates, allowing for little slack if a greater than expected number of patients need to be admitted from the ED.<sup>179</sup> More centralized public control and funding of our hospital system would allow us to determine, through an open and public process, whether we wish to commit the additional revenue it would take to increase inpatient bed capacity in areas regularly experiencing overcrowding and other issues.<sup>180</sup> Seeking greater public control of our hospital system in response to this one issue alone is surely excessive. Nevertheless, we must add the issue of ED overcrowding and its causes to the list of reasons we may want to rethink our present system of hospital organization, control, and finance.

## CONCLUSION

EMTALA was intended only to be a stopgap measure until Congress finally succeeded in implementing universal or near-universal health coverage.<sup>181</sup> The crises in emergency care demand attention. We can take a number of small steps to improve care and reimbursement under EMTALA. Nevertheless, ED overcrowding,

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<sup>177</sup> *Id.*

<sup>178</sup> See *supra* notes 120-24 and associated text.

<sup>179</sup> See *supra* notes 120-21 and associated text.

<sup>180</sup> Such a system is not, however, a panacea for the problem. See, e.g., D. M. Fatovich et al., *Access Block Causes Emergency Department Overcrowding and Ambulance Diversion in Perth, Western Australia*, 22 *EMERGENCY MED. J.* 351 (2005); Laura Eggertson, *ED Problems Result of Bed Shortages, Doctors Contend*, 170 *CAN. MED. ASS'N J.* 1653 (2004).

<sup>181</sup> See *supra* note 97 and associated text.

along with the ever-rising tide of the uninsured, suggest that EMTALA can no longer stave off the need to revisit plans to implement universal health coverage in this country.

In 2004, 45.8 million Americans, or 15.6% of the population, were uninsured.<sup>182</sup> Medicaid covered another 12.4% of the population.<sup>183</sup> These individuals represent the bulk of the “undesirables” in the U.S. healthcare system—those from whom private hospitals and other providers can expect the least economic return, and have the least interest in treating. While they may lack resources, the uninsured are not the primary cause of the present problems our emergency departments are experiencing. Rather, a combination of factors, including increased ED use by both insured and uninsured populations, an increase in the severity of illness with which ED patients are presenting, and an inadequate supply of available inpatient beds for ED patients who need to be admitted, contribute significantly to the problem. Changes in healthcare finance that have constricted the ability of providers to shift costs from unprofitable to profitable ventures, and from the poorly insured to the well insured, and that have thrown the healthcare market open to increasing competition among private providers, have placed further tensions on EDs. The solution to these problems has little if anything to do with EMTALA itself. Rather, they are symptoms of greater problems within the healthcare system of this country.

There are, to be sure, smaller steps we can take to help ameliorate certain problems with the provision of emergency care in the United States. We can federally prohibit managed care organizations from requiring preauthorization for care given in EDs in order to be reimbursed. We can also expand eligibility and improve provider reimbursements for our public healthcare programs. But as long as we continue with our present largely voluntary and private system of healthcare, we will continue to face significant problems that impact well beyond ED overcrowding. As noted in Congress two decades ago, EMTALA was meant merely to be a stopgap measure to help protect some of

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<sup>182</sup> See DENAVAS-WALT ET AL., *supra* note 72, at 16.

<sup>183</sup> See *id.* Medicare covered 13.7 percent. *Id.*

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the most vulnerable members of our populace until we overhauled our system of health insurance and healthcare organization and finance. It is time once again to set ourselves to this task.