

‘TAKING’ MEDICAL CARE FROM HOSPITALS

The Emergency Medical Treatment and Active Labor Act infringes the Fifth Amendment.

◆ BY HAAVI MORREIM

The Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986, requires Medicare-contracting hospitals with emergency rooms (ERs) to screen and stabilize anyone presenting for emergency care, regardless of ability to pay. The law has played a pivotal and peculiar role in American health care as the only assured access to care for millions of people.

Curiously, although EMTALA imposes enormous costs on hospitals, the statute provides no compensation for the services it mandates and neither the Supreme Court nor any circuit courts have addressed its constitutionality. This article proposes that EMTALA regularly violates the Fifth Amendment’s Takings Clause: the government *takes property for public use* without *just compensation*. As shown below, the basic elements of a taking (often dubbed “eminent domain”) can be readily established: property, taking, and public use. EMTALA then becomes unconstitutional any time the taking is not justly compensated.

The conclusion is not that hospitals should ignore those who lie crushed and bleeding while they search the wreckage for an insurance card. Rather, when the federal government commandeers resources from hospitals under EMTALA, the Fifth Amendment requires that the hospitals be justly compensated. At present, hospitals annually incur billions in uncompensated EMTALA losses.

As discussed below, the government cannot bypass this challenge by labeling EMTALA a mere condition of participation (CoP) in Medicare, saying, “If you want our money, you must follow our rules.” Ordinary Medicare CoPs are program-integrity requirements to ensure that Medicare’s elderly and disabled ben-

eficiaries get what they and the government pay for—quality and quantity of services, properly billed. EMTALA has a completely different purpose. It leverages hospitals’ financial dependence on Medicare (averaging as much as 30 percent of hospitals’ revenues) to coerce them to provide free services to a completely different population: people who show up in the ER. Arguably that amounts to what the Supreme Court calls an “unconstitutional condition.” Once it becomes clear that EMTALA really does impose takings on hospitals and that it cannot be justified as simply a string attached to federal funds, all that remains in the Takings analysis is to figure out just compensation.

One additional wrinkle is worth noting: EMTALA plays a pivotal and likely growing role in health care economics. Historically the law has provided a safety net for millions of people with no other access to health care. Going forward, it will likely encourage many to remain uninsured, despite the 2010 Patient Protection and Affordable Care Act (ACA) mandate that virtually everyone have health insurance. As discussed below, the incentives to forgo insurance emerge from several factors. Health care remains costly, perhaps more from hefty cost-sharing than from premium costs. The tax “penalty” for failure to be insured is largely unenforceable, hence providing limited impetus to buy coverage. The uninsured who subsequently become ill can then buy full insurance for the same cost as anyone else and, in the meantime, they can always go to the ER. If enough healthy people forgo insurance, premiums will likely rise, discouraging still others from buying insurance, in turn potentially triggering something of a “death spiral” in which essential risk-spreading cannot be assured.

This article proposes—although neither endorsing nor disparaging the idea—that the individual mandate could be given force via the very same Takings analysis propounded here. In lieu of a weak, largely unenforceable tax, the individual mandate could be recast via eminent domain. The property taken: the citizen’s money. The just compensation: a health plan. The public use:

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salvaging a health care system based on private insurance.

Ultimately, although EMTALA as a longstanding statute is unlikely to be overturned any time soon, it is important to consider the constitutional legitimacy of legislation carrying such enormous impact.

PROPERTY

We begin by showing that EMTALA's mandate really does implicate the Fifth Amendment: the government takes private property for public use. Classic eminent domain usually involves real estate. The state needs Farmer Brown's land to build a new road; hence it takes title to the land, pays Brown "just compensation," and builds the road. Personal property is equally susceptible to government taking, including money, intellectual property such as trade secrets, and ordinary objects of daily life. Here, the personal property hospitals provide to ER patients includes everything from pharmaceuticals, bandages, and costly medical devices, to paid employee time and the rental value of an operating room or intensive care bed. Importantly, the hospital itself is not the "property" in question. Rather, the hospital is the (corporate) "person" whose property is taken.

Although technically a hospital's EMTALA obligation ends when someone is admitted as an inpatient, EMTALA-generated costs often include ongoing inpatient expenses. In pre-EMTALA days when hospitals could simply transfer an indigent ER patient to a public or charity hospital, they could avoid the great majority of those patients' costs. EMTALA forbids that so long as the patient is not stable. Additionally, a hospital with specialty services such as a burn unit or newborn intensive care must accept incoming transfers of patients who need those services, even if the hospital has no ER and even if the patient will never pay.

TAKING

Over the years, courts' definition of a taking has evolved into two general kinds. "*Per se*" takings are the oldest and most familiar, as with Farmer Brown's land. The government ousts the original owner and becomes the new owner. The other kind, "regulatory taking," mainly applies to land use, and it emerges from the need to strike a somewhat delicate balance. On one hand, although government must sometimes regulate property in ways that may adversely affect its value, usually this is just the price we must pay for living in society. Perhaps I would dearly like to turn my home into a geriatric strip club, marketing the business to aging baby boomers. Alas, if my house sits next door to an elementary school, the zoning board will likely not approve. Although surely the home's value would be greatly enhanced by octogenarian pole-dancers, I must absorb the loss with grace.

On the other hand, sometimes government regulation is so intrusive that it essentially amounts to an ouster. The property does not literally change hands, but its value is so diminished that the government must compensate the owner. In a classic case from World War II, low-altitude flights from a military airfield were so upsetting to the flocks at Lee Causby's chicken farm that the Supreme Court found Causby's poultry business had become nonviable and required the government to pay the farmer for its taking, even though Causby still owned the farm. By 1978 the Court provided more detailed criteria to help subsequent courts determine whether a particular regulation was simply the price of living in a community or whether it had such adverse effects on a property that it amounted to a "regulatory taking" requiring compensation.

Over time the Court also clarified its description of *per se* takings into two types: (a) complete destruction of the property's value, or (b) physical invasion or occupation. The Court found complete destruction in *Lucas v. South Carolina Coastal Commission*

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(1992). David Lucas bought oceanfront land to build a housing development, but subsequent zoning restrictions forbade that use of his land, rendering it effectively worthless. No nuanced regulatory analysis was required, the Court said. Because all economically beneficial uses of Lucas's property had been precluded, this constituted a *per se* taking.

The other type—physical invasion or occupation—emerged in *Loretto v. Teleprompter Manhattan CATV Corp.* (1982). As the cable television industry emerged during the 1960s and 1970s, the State of New York authorized cable companies to install their equipment on sides and tops of buildings, including Jean Loretto's apartment building, even if the building's owner did not subscribe to that particular cable service. The Supreme Court ruled that, although only small bits of Loretto's building were occupied by the cables and boxes, those installations constituted a physical invasion and thereby a *per se* taking.

Similarly, in *Nollan v. California Coastal Commission* (1987), James and Marilyn Nollan were told that as a condition for rebuilding their beachfront home, they would be required to grant public access across their beach so that people could walk from a state beach on one side of the property to another park on the other side. The Court did not assume that beachwalkers would be traipsing across the Nollans' land at every moment of the day and night. Rather, the Court emphasized that the property owners had lost the most essential element of property rights: the right to exclude. Therefore, a taking requiring compensation has occurred.

Arkansas Game & Fish Commission (2012) is particularly helpful. The Corps of Engineers' dam control activities caused intermittent flooding on state game and fish lands, requiring costly environmental repairs every time. A unanimous Court deemed this intermittent flooding a taking even though the floods did not constitute a permanent invasion of the land.

EMTALA's takings are now evident. They are not regulatory land-use takings governing the hospital as a whole. Rather, they are *per se* takings of both types. First, the value of personal property is completely destroyed: the costly pharmaceutical or bandage is entirely consumed, and the hour of nursing or physician time is completely spent. Second, spaces are physically invaded: the ER cubicle, the operating room, the intensive care unit bed. EMTALA routinely subjects hospitals to an "intermittent flood" of needy patients and imposes on the hospital a servitude in which it has lost the property owner's fundamental "right to exclude." It would be no different if the government required that on cold nights, every Ritz Carlton, Hilton, and Marriott must open their rooms to the homeless, without compensation either for the invasion of space or for the consumption of resources such as staff time, towels, and toiletries.

PUBLIC USE

EMTALA's public use is to ensure immediate emergency care, regardless of ability to pay. Surely this is a requirement we can endorse, for any of us could be the person broken and bleeding,

with no insurance card near. As a society, we may feel we have crossed the wrong moral line if we throw a dying person out onto the streets simply because he cannot prove his solvency.

Admittedly, these takings are not the typical sort in which the government itself commandeers property. Rather, government mandates a property transfer from one private party (the hospital) to another (the patient). However, this kind of taking was expressly recognized in *Kelo v. City of New London* (2005). In an attempt to revive the city's faltering economy, New London required homeowners to sell their land—including waterfront homes that had been in the family for generations—to private developers as part of a community revitalization plan. The Court held that such private-to-private transfers can indeed satisfy the "public use" requirement when it is the government requiring them.

MEDICARE CONDITION OF PARTICIPATION

A predictable response to all this says there really is no problem: EMTALA is simply a condition of participation in Medicare. Government says, "If you want our money, follow our rules." Because participation in Medicare is voluntary, hospitals cannot complain that they do not like some of its requirements. They can simply withdraw from the program or shut down the ER and specialty facilities EMTALA covers.

This response has a number of problems. To begin with, surely it would be poor public policy to encourage hospitals to stop participating in Medicare just as baby boomers are joining *en masse*, or to shut down ERs and specialty services. However, the problems run much deeper. EMTALA may well be completely unconstitutional. Here's why:

Medicare creates a fairly ordinary insurance contract between health care providers (here, hospitals) and the government. Providers furnish goods and services to Medicare beneficiaries and, like other insurers, the government pays for them. Like many private insurers, the government also seeks program integrity to ensure that beneficiaries receive the appropriate quality and quantity of goods and services, and that billing is done correctly. Medicare CoPs thus focus on health, safety, and financial standards.

EMTALA is a completely different genre of CoP. It has nothing to do with quality assurance. Rather, it demands that hospitals hand out goods and services completely outside of the main insurance contract for the elderly, to an entirely different population (anyone who comes to the ER or needs certain specialty services). Arguably, the law amounts to what the Supreme Court dubs an "unconstitutional condition."

Although the doctrine of unconstitutional conditions is not a model of clarity, the jurisprudence generally steers a course between two important principles. On one hand, just as the government is empowered to tax and spend for the general welfare, so is it permitted to make sure that its funds are used as intended—to place *conditions* on the funds' use. On the other hand, the Constitution provides important protections, e.g., in the Bill of Rights. The

government can cross an impermissible line when “strings” on its funds force citizens to give up important constitutional rights.

Thus, in *Rust v. Sullivan* (1991) the Court found the government could legitimately require that federal funds not be used to promote abortion as part of family planning. The purpose of the program was to promote family planning in ways that did not involve abortion, and recipients of those funds still had other ways to advocate abortion if they wished. The regulation was on the *program*, not on the *recipients* of the funds. Other cases likewise affirm the government’s right to attach conditions to its funded programs, to ensure that the money is spent as intended.

In contrast, in *Agency for International Development v. Alliance for Open Society International* (2013), a government program to combat HIV and other diseases worldwide required funding recipients to embrace a policy opposing prostitution. Clearly a straight-out government requirement that people oppose prostitution would run afoul of First Amendment guarantees for freedom of speech and thought. In this case, imposing that same mandate as a condition for receiving federal funds violated the Constitution because it would regulate speech even outside the contours of the funded program.⁷

Cases featuring “unconstitutional conditions” have spanned the Bill of Rights. The *Nollan* case, mentioned above, concerned the Fifth Amendment’s Takings Clause. The Nollans wanted to rebuild their beachfront home, but the Coastal Commission would only grant their building permit on condition that the Nollans allow the public to traverse their property from one end to the other. Clearly the government could not have directly ordered the Nollans to allow strangers to traipse across their back yard at will. That would obviously be a taking (of an easement), requiring compensation. Admittedly the state could have denied the permit entirely. However, the Court held that when the state leveraged its power over the permit process to exact a concession that lay outside the purposes of the statute, it imposed an extortionate demand. That demand impermissibly burdened the Nollans’ Fifth Amendment right not to have property taken without just compensation.

Dolan v. City of Tigard (1994) echoed the theme. When Florence Dolan wanted to expand her electrical and plumbing supply store and pave its parking lot, the city required her not only to dedicate some of her land as greenway for flood control, but also to grant a 15-foot easement for a pedestrian and bicycle path. The Court ruled that those demands attached an unconstitutional condition to the permit process, particularly emphasizing that any condition tied to such a permit must be proportionate to the landowner’s adverse impact on the community. Here, the city proffered no evidence to suggest that the store’s expansion would have such a large effect on flooding or traffic as to require such a large land concession, let alone give up Dolan’s right to exclude the public from her land. Recently, *Koontz v. St. Johns River Water Management District* (2013) reinforced the same principles in another building permit case.

The jurisprudence of unconstitutional conditions is more complex than this brief article can describe. However, several themes emerge:

- **Threshold:** Where the government could not directly demand something—e.g., as the government cannot simply order someone to hand over private property without compensation—then demanding that same thing indirectly, as a condition attached to federal funds, triggers close scrutiny.
- **Germaneness:** Government can create programs to benefit the general welfare, and can attach conditions to ensure those funds are spent as intended. However, government may not attach conditions that are not actually relevant to the program’s purpose. It is one thing, for instance, to stipulate that federal funds for public television must not, themselves, be used for lobbying or editorializing. It is quite another to forbid a person or organization receiving such funds from ever lobbying or editorializing, even outside the parameters of the funding. The latter would reach beyond the purposes of funding public programming.
- **Proportionality:** Constitutional rights must not be overly burdened, even when permissibly constrained. If it is acceptable to require a landowner to offset the flooding hazard he might cause, it is not acceptable to require vastly more than that.
- **Coercion:** Coercion has been an underlying theme of unconstitutional conditions cases. The Court has been clear that when “strings” on federal money lack germaneness and proportionality, the result can be extortionate. Thus, federal funds should not be used as leverage to extract inordinate concessions.

By all four criteria, EMTALA appears to be an unconstitutional condition imposed on Medicare-contracting hospitals. Consider:

- **Threshold:** Clearly the government could not directly require hospitals to hand out goods and services to people who come to the ER—without paying just compensation—any more than it could order Ritz hotels to house the homeless without compensation. Both would violate the Fifth Amendment’s Takings Clause. By making this very same demand a condition for hospitals to participate in Medicare, the government heavily burdens a constitutional right and we must have a high index of suspicion that it could run afoul of the Constitution.
- **Germaneness:** Medicare was enacted in 1965 to provide health insurance to elderly Americans. Although a few disability conditions were added over the years, the program’s purpose has always been health care for the elderly. Thus, EMTALA’s enactment over 20 years later was not merely an incremental tweak; it was a dramatic transformation. Suddenly, as a condition attached to their opportunity to care for the elderly, hospitals were expected to screen and stabilize anyone with an emergency condition, regardless of age. And hospitals with specialty services such as burn units

or newborn intensive care units were suddenly required to accept anyone in need. It appears the legislature leveraged hospitals' financial dependence on Medicare to achieve an objective completely unrelated to the program's purpose.

- **Proportionality:** If EMTALA is only marginally relevant to the elderly (whose emergency care, after all, was already covered by Medicare), its financial impact on hospitals is enormous. Estimates suggest that about half of all emergency services are uncompensated, tallying roughly \$6 billion per year, and that has contributed to closing hundreds of ERs nationwide. And this figure does not count even greater EMTALA-generated costs for still-unstable ER patients who must be admitted as inpatients, or those receiving EMTALA-mandated specialty care.

While this article cannot fully address it, the proportionality requirement is likely not met. After all, the identified "beneficiaries" of the Medicare program are not hospitals at all, but rather elderly and disabled persons. To the extent that hospitals "benefit," it is simply by earning fair market value (sometimes less) for providing services to that population. Fair value for services is not government largesse; it is simply a benefit-of-the-bargain for both parties. It is not clear how government could consider itself entitled to demand that hospitals incur additional billions in losses simply to spare the government from having to pay for the services itself. The "price" appears considerably out of proportion to hospitals' "benefit."

- **Coercion:** Coercion is a theme underlying unconstitutional conditions jurisprudence. The government leverages the party's dependence on a government benefit to extract a waiver of constitutionally protected rights that it would not otherwise be able to secure. In EMTALA the opportunity for coercion is evident. Medicare now averages some 30 percent of hospitals' overall budgets—hardly something many hospitals could abdicate simply to be free of EMTALA's uncompensated burdens. It is a Scylla-Charybdis choice. Although the percentage was perhaps different in 1986 when EMTALA was enacted, even then hospitals had relied on Medicare as part of their core of insured services for 20 years. With such high-level financial dependence, it cannot likely be said that absorbing EMTALA's uncompensated burdens has ever been particularly "voluntary."

Interestingly, the Supreme Court discussed those last three elements—relevance, proportionality and coercion—in its 2012 decision mostly upholding the ACA. In *NFIB v. Sebelius*, the lone ACA element struck down was the requirement that states expand their Medicaid programs to cover all of the poor (not just some of them) up to 133 percent of the federal poverty line—a requirement states were to honor on pain of losing all Medicaid funding. Although the Court did not expressly address the issue under the "unconstitutional conditions" rubric, it nevertheless ruled

that requiring states to broadly expand Medicaid as a condition of continuing in the program was unconstitutional.

First, the economics were unduly coercive. This was not mild encouragement; it was a "gun to the head." "The threatened loss of over 10 percent of a State's overall budget ... is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."

Second, the expansion represented a program change not merely in degree, but in kind. Medicaid was initially designed to cover four categories of the needy: the disabled, blind, elderly, and needy families with dependent children. Expanding to encompass every indigent man, woman, and child below a specified income threshold was not a mere tweaking of the program; it was a dramatic transformation. This exceeded Congress's authority because it "surpris[ed] participating States with post-acceptance or 'retroactive' conditions."

Although the Court was discussing the federal government's relationship with the states, the same reasoning could extend readily to EMTALA and Medicare. If threatening 10 percent of states' budget by withdrawing Medicaid represents "gun to the head" "economic dragooning," surely denying 30 percent of hospitals' revenues would be financially more coercive. Likewise, the 1986 addition of EMTALA obligations completely transformed Medicare from health care for the elderly to encompassing every person needing any form of emergency care or specialty service, regardless of age. Surely this is a far more fundamental post-hoc transformation than merely adding more low-income people to a Medicaid program that already focuses on low-income people.

In sum, EMTALA arguably is unconstitutional as a condition imposed on hospitals' participation in Medicare. Rather, it represents a series of takings requiring just compensation.

JUST COMPENSATION

Once we recognize that EMTALA commits systematic acts of eminent domain, all that remains is a fight about the money. The taking is not what is unconstitutional; it is the lack of just compensation. Though this brief article cannot provide a thorough analysis, a few observations are in order.

First, a longstanding principle called "quantum merit" holds that when someone knowingly receives something of value, he must ordinarily pay for it. Thus, the patient should pay fair market value for his or her emergency care. This does not mean, however, that if the EMTALA patient fails to pay, the hospital must simply chalk it off as bad debt. The government that exacted a taking from the hospital must be the guarantor of payment: if the patient fails to pay, the government must do so and perhaps then go after the patient for reimbursement. Recall the *Kelo* case summarized above. If the company buying Susette Kelo's land had failed to pay for it, the government could not say: "Gosh, Susette, too bad you got stiffed. Looks like you'll need to chalk that one off as bad debt." Rather, the government that forced the taking must ensure, one way or another, that just compensation is paid.

Second, as we consider government payments, different types of hospitals raise different compensation issues. For-profit hospitals pay a full load of taxes and ordinarily have no legal obligation to render free care. Hence, where no one pays for the care, EMTALA services represent unconstitutional takings.

Not-for-profit hospitals present complexities. They are spared substantial tax levies in exchange for an obligation to provide charity care or other community benefits. Free care through the ER could surely count. However, these hospitals can fulfill their obligations in other ways, and at some point they have “done enough.” At that point, wherever it may be, their uncompensated emergency care becomes an unconstitutional taking.

State and locally funded public hospitals pose yet another challenge. The Supreme Court has long been clear that the federal government is not permitted to commandeer states to do its business. Where a state or city has funded a hospital to serve its own specific purposes, it is not clear that the federal government has any right to commandeer those local resources to meet federal demands, potentially to the detriment of the state’s own purposes.

Across all three types of hospital, a separate issue concerns adequacy of compensation. Many hospitals suggest that Medicare payments are often inadequate to cover even the cost of the services it pays for, potentially adding another dimension of taking. Compensation must be “just,” not less.

The details of EMTALA payments are left to be debated elsewhere. The important point here is that when an EMTALA patient’s care is not justly paid for, the taking is unconstitutional.

AN OMINOUS PREDICTION AND A TWIST. . .

We turn now to policy implications and a story of two statutes—EMTALA and the ACA—on a collision course. Over the years, EMTALA has been a “fig leaf” hiding the nation’s lack of broad access to health care. After all, the uninsured can always go to the ER. Going forward, EMTALA is likely to become an “enabler,” helping large numbers of people to forgo buying health insurance. The ACA mandates that nearly everyone have health insurance, which is essential to risk-spreading now that “guaranteed issue” and “community rating” let everyone buy insurance regardless of preexisting conditions, and essentially for the same price as everyone else. The mandate is designed to ensure that people do not, figuratively speaking, wait until the house is on fire to buy home insurance.

Unfortunately, the current structure might well enter a financial death spiral. First, it is far cheaper to pay the “tax” (penalty), for failure to be insured, than to buy insurance. This difference is built into the statute and is, indeed, a major reason the Court upheld the ACA: the consequence for being uninsured is so much smaller than the cost of insurance that it can rightly be deemed a tax, not a penalty. As a result, people with car payments, student loans, and other financial priorities may find it more attractive to pay the penalty than to buy costly insurance if they are currently

healthy. Those who later become ill can then buy insurance for the same price as anyone else. Additionally, most plans feature 20–30 percent cost-sharing. Where one must first pay a large sum out of pocket, it may make more sense to leave money in that pocket than shell it out for insurance.

Second, the mandate is largely unenforceable. Failure to be insured is not a crime and the Internal Revenue Service, charged with enforcement, cannot place liens or levies on property to collect the tax. The IRS can only send an uninsured taxpayer a stern letter and take money from that person’s tax refund, if there is any. Uninsured persons may quickly realize they can adjust withholding to leave little or no refund for the IRS to take.

Third, those who decline to buy insurance still can rely on the ER whenever they need care. After all, hospitals must provide emergency care regardless of ability to pay.

If enough healthy people forgo insurance, premiums will likely rise. At that point some of the smaller businesses that currently insure their workers may opt to pay a penalty and send employees to the insurance exchange. At that point a whole new population of people, previously insured, will have the choice whether to buy insurance. If sufficient numbers of healthy people decline to do so, the cost of insurance will predictably rise still further. And on and on.

An individual mandate with no real enforceability thus poses a serious risk to the ACA’s viability. Perhaps surprisingly, eminent domain as discussed above might provide the fix. The following description is not intended to endorse either the ACA or the mandate, but simply to trace out some financial implications and identify an avenue that could logically meet the challenge.

The ACA’s insurance mandate could be implemented, not as an easily avoidable tax, but as a bona fide act of eminent domain. The *public use* would be to preserve the viability of a health care system financed by individual insurance policies. The *property* to be *taken* is the individual person’s money. And the *just compensation* is health insurance for that individual.

Interestingly, recasting the mandate as an act of eminent domain need not pass constitutional muster under either the Commerce Clause or the Tax and Spend Clause—a major focus of *NFIB v. Sebelius*. Rather, the Court has long been clear that, in assessing challenges to eminent domain, courts must be highly deferential to legislatures, applying only a rational basis review in which the law will be deemed constitutional so long as it bears a rational relationship to a legitimate government interest.

CONCLUSION

EMTALA, on the books for nearly 30 years, is unlikely to be overthrown any time soon. Nevertheless, even though the ACA has broadened insurance coverage, millions of people will remain uninsured, relying on the ER as their primary source of care. Hospitals’ burdens are unlikely to disappear any time soon. Perhaps it is time to consider seriously whether the government must pay for the great burden it imposes. R