HEALTH & MEDICINE

# NO DISCHARGE: MEDICAID AND EMTALA

*The federal law that requires hospitals to treat indigent cases harms health care access and affordability.*

BY JEFFREY A. SINGER

The history of American public policy is littered with tales of Congress reacting to a disturbing event by usurping the authority of local and state governments and enacting one-size-fits-all national legislation. More often than not, the unintended consequences of such federal intervention have far-reaching deleterious effects on society—effects that can negate hoped-for positive outcomes.

A case in point is the Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986. Congress adopted the legislation in response to a series of disturbing stories in the national media regarding the transfer between medical centers of improperly stabilized patients. Yet, EMTALA is unnecessary and even redundant. Worse, it distorts the health care marketplace, harming hospitals, patients, insurance companies, and businesses.

In this article, I tell the story of how the act came to be, describe the harms it has caused, and suggest some solutions to its unintended consequences. I also examine how the consequences of the law have been used to justify further intrusions by the federal government into the powers reserved to local and state governments or to the people.


## HISTORY

In the mid-1980s, the press reported several stories about the transfer of indigent patients to indigent care centers because the patients lacked health insurance or financial resources. Some of those patients were pregnant women in active labor. In a few cases, the transfers resulted in deaths.

In 1986, a highly publicized *New England Journal of Medicine*

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article by D. A. Ansell and R. L. Schiff detailed the extent of such transfers—called "dumping"—to Cook County Hospital in Chicago. A follow-up article appeared in the *Journal of the American Medical Association* the following year. The majority of those transferred indigent patients were minorities and unemployed. The articles reported that the principal reason given for the transfers was lack of insurance, and only 6 percent of patients had given informed, written consent for a transfer. Ansell and Schiff concluded that 24 percent of the transferred patients were moved in an unstable condition, and they were twice as likely to die as patients who were not transferred. The research further showed that "dumping" was not limited to Chicago, citing as an example 200 such transfers to indigent hospitals in Dallas in 1983.

In response, Congress enacted EMTALA as a four-page section within the Consolidated Omnibus Budget Reconciliation Act of 1985 (actually enacted in 1986). EMTALA ignored the fact that safeguards for indigent patients already existed in law. In fact, the Joint Commission on Accreditation of Hospitals (a private, nonprofit accrediting agency) stated in its 1984 *Accreditation Manual,* "[I]ndividuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, nationality, or sources of payment for care." The American College of Emergency Medicine had similar language in its bylaws. The Hospital Survey and Construction Act of 1946 established federal guidelines for emergency care at certain hospitals, and many states had laws prohibiting discrimination in the provision of emergency care.

More important then—and today—is the presence of medical malpractice laws in the states. Patients can only be transferred if their physicians declare them stable for transfer, and only if the receiving doctors agree to accept the patients. The responsibility for the patients' safety rests with the transferring and receiving physicians. If a transfer is medically inappropriate, the liability rests with the doctors. The civil tort system provides perhaps the best disincentives for physicians providing substandard care. Those economic disincentives arguably have a greater effect on


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physician conduct than do hospital accreditation or professional association behavioral guidelines. EMTALA effectively federalized an area of state tort law that was more than adequate to the task of discouraging such malpractice.

It may be argued that the malpractice system provided imperfect deterrence in the cases cited by Ansell and Schiff because restitution or punishment takes place after the fact. Of course, the same argument can be made with respect to the civil and criminal justice systems in general, when dealing with matters of restitution or punishment. Any attempt at deterrence employing prospective rather than retrospective measures requires an almost omniscient control over the actions and judgments of others and, as outlined below, yields many deleterious unintended consequences.

Ironically, 25 years after its passage, it is unclear whether EMTALA has solved the problem of patient dumping. A June 2001 report to Congress by the U.S. General Accounting Office found that the "overall impact of EMTALA is difficult to measure, however, because there are no data on the incidence of patient dumping before its enactment, and the only measure of current incidence—the number of confirmed violations—is imprecise."

## THE LEGISLATION

EMTALA is primarily directed at hospitals, not doctors. Typically, for a hospital to provide services under the Medicare or Medicaid programs, it must first be certified by the Center for Medicare and Medicaid Services (CMS). EMTALA only applies to CMS-certified hospitals, which constitute about 98 percent of the nation's hospitals. Veterans Affairs hospitals, most military hospitals, Indian Health Service hospitals, and Shriners Hospitals for Children are among those exempted from CMS certification.

EMTALA mandates that, upon the presentation of a patient to a CMS-certified hospital (or certain parts of that hospital's campus), the patient must be screened to see if he or she has an emergency condition, without any regard to financial or insurance status. If the screening shows an emergency medical condition, then the patient must be stabilized and may not be discharged from the hospital or transferred from the department until deemed stabilized or "appropriately" stabilized for transfer. An emergency medical condition could require several days in the hospital until the patient stabilizes; examples include an intestinal obstruction, acute gallbladder attack, acute appendicitis, stroke, heart attack, impending heart attack, and congestive heart failure.

Patients may only be transferred if they request transfers or are in need of a service, such as neurosurgery, that might not be available at the current facility. In such cases, any facility offering the needed services is mandated to accept patients who are stabilized for transfer.

The act goes on to very broadly define the parameters of "stability," "stabilization," and "appropriateness" of transfers. The act intentionally keeps those definitions broad and generic so as not to intrude on varying state medical malpractice laws.

EMTALA places very few requirements on physicians. It primarily requires on-call emergency room physicians to care for patients in accordance with EMTALA guidelines or else face civil fines (up to $50,000 per occurrence) or possible expulsion from the Medicare and Medicaid system. All hospitals that have emergency departments must maintain an on-call schedule of physicians. The physicians must care for every patient who comes to the emergency department, regardless of financial status.

Penalties to hospitals for violating EMTALA include civil monetary fines of $50,000 per violation, liability for damages to the injured patient in a civil action under the federal statute, and loss of CMS certification. That last penalty, known as the "Medicare Death Penalty," provides the strongest incentive for hospitals to comply with EMTALA. Given that Medicare recipients make up a third of hospitalized patients, loss of access to the over-65 population would severely threaten the financial viability of the typical general hospital. With almost no exception, if a hospital were to lose its CMS certification, it would have to shut its doors.

EMTALA is the law of the land in all 50 states. No CMS-certified hospital is exempt from EMTALA. However, the act grants a waiver in the case of state-based emergency preparedness and pandemic preparedness plans. In "state of emergency" situations, EMTALA's requirements regarding "stabilized" and "appropriate" transfers may encumber implementation of the state's emergency plan. Under those circumstances, a waiver is available. But even under the waiver, decisions to transfer patients under a state's emergency plan still cannot take the patient's financial status into account.

## CONSEQUENCES

Prior to the creation of Medicaid in 1965, states, counties, and municipalities developed their own indigent health care program, each informed by the local knowledge of their communities. Typically that care was provided by publicly owned, publicly funded hospitals that were often affiliated with medical schools. Most nonprofit hospitals had charity wards and maintained constant populations of charity patients who were cared for by private physicians on the hospital staff. Religious-affiliated hospitals also operated charity clinics in addition to charity wards. All practicing physicians, as part of their professional credo, provided a significant amount of uncompensated care. In order for hospitals and providers to maintain control over their caseloads, indigent patients would be transferred when necessary to facilities that could accommodate them.

***Case study*** / As a surgeon practicing in Phoenix, Ariz., I have personal knowledge of the charity systems that once operated in the state—especially the system for Maricopa County. Arizona required each county to establish an indigent care system, to which the state gave matching funds. The systems consisted of networks of primary care and mental health centers, as well as

one or more medical centers, and cooperated with a network of small and large nonprofit and religious-affiliated hospitals that also provided charity services. The Maricopa County Medical Center, built in the state's largest county, was the heart of the system. The medical center included a Level 1 trauma center and the largest burn unit in the Southwest.

However, to control costs, the medical center accommodated patients in a ward setting—often four or six patients to a room—and was staffed with salaried physicians who were willing to work for less money than they could earn in the private sector. The physicians supervised and were responsible for interns and residents who, in turn, provided the bulk of patients' care. Care delivery was standardized; for example, there were protocols and guidelines that needed to be met in order for certain tests or procedures to be obtained. Equipment and supplies in the clinics and operating rooms were standardized as well, so that practitioners had to adjust their techniques and preferences to fit the circumstances.

That contrasts sharply with the way medicine is practiced at private and nonprofit medical centers, where costs are much higher. For example, such hospitals have private and semi-private rooms with an emphasis on amenities designed to attract patients who have a choice of hospitals. Also, there is often a great redundancy in equipment and supplies, and much less standardization of care, so as to satisfy the requests—and sometimes the idiosyncrasies—of attending physicians who also have a choice of hospitals.

Patients whose income and assets made them eligible for care through the Maricopa County system received a card to obtain care at one of the various primary care centers. Those who were in need of hospitalization were cared for in a ward setting at the Maricopa County Medical Center, but the facility was available to all people in the county.

Indigent patients who sought care at other hospitals would often be transferred, if stable, to the county medical center, where they would receive treatment and become enrolled in the county's full health care system retroactively. After receiving care, all patients would receive a bill from the hospital. Even the indigent patients who were pre-enrolled in the system were put on a payment schedule tied to their ability to pay. In this way, the publicly funded system was more charity-based and less of an entitlement.

***EMTALA and Medicaid*** / In 1982, after receiving a waiver allowing it to design a partially privatized managed care model, Arizona became the last state to join Medicaid. Arizona is currently responsible for roughly a third of the state program's funding, while the federal government provides the rest. Across the nation, the federal/state shares vary with the state population's federal poverty level.

Despite limits on the federal share and states' significant contributions, states are expected to comply with myriad rules and requirements established at the federal level, and their basic plan for meeting indigent health care needs must fit a federally prescribed model. Adjustments can be made in the design of each state's indigent health plan, provided the state obtains a waiver from CMS.

In the Medicaid program, patients receive care at various hospitals (public and private) and from participating health care providers throughout the community, many of whom are independent private practitioners as opposed to salaried hospital staff overseeing residents. Medicaid functions just like a health insurance plan, except that the beneficiary does not have to pay any premiums or co-pays. Medicaid pays the hospitals and providers directly, according to a fee schedule that is usually well below market rates. The low reimbursement rates are causing an increasing number of health care providers to opt out of Medicaid participation.

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Over the last several years, the financial burden the Medicaid program has placed on states has become increasingly onerous. In addition, provisions in the 2010 Patient Protection and Affordable Care Act require states to increase the number of patients enrolled in Medicaid while also increasing their share of the costs, eventually to 60 percent. This has stimulated a movement in some state legislatures to consider opting out of the Medicaid program and reestablishing their own indigent care systems.

The passage of EMTALA in 1986 has unintentionally blocked such an option because EMTALA implicitly assumes the existence of the Medicaid model. EMTALA's prohibition on hospitals transferring patients for financial reasons effectively precludes a state from adopting any indigent care model resembling what existed in pre-1982 Arizona. And a state could not replicate the Medicaid model after losing the federal share of matching funds. Medicaid outlays for the 2009 fiscal year demonstrate that, if a state were to opt out and attempt to adopt an indigent care system that only reimburses hospitals and providers for acute care (typically emergency room) patients, the savings realized would not be enough to offset the cost of such a bare-bones program because the state's hospitals would still have to comply with EMTALA even though the state is giving up federal money.

According to the most recent data available from the U.S.

Department of Health and Human Services, the federal share of acute care costs in the Medicaid program totaled $100.4 billion in 2009. Those costs are essentially fixed because EMTALA largely precludes higher-cost facilities from transferring indigent acute care patients to lower-cost facilities, so we know that is a pretty consistent cost that states will have to pay. In contrast, a state's share of all other services normally provided by Medicaid amounts to $68.6 billion. If states opt out of Medicaid in order to create a bare-bones indigent care system that only pays for the cost of acute care for indigents in compliance with EMTALA, the savings realized ($68.6 billion in state funding) would be more than $30 billion short of covering the $100.4 billion in acute care costs they would likely face with the total loss of federal Medicaid funding.

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Thus, because of EMTALA, a state that opts out of Medicaid could not even afford a basic system that solely provides reimbursements to hospitals and providers for patients appearing in their emergency rooms. Local tax increases would be unavoidable in order to fund what many would argue would be a grossly inadequate indigent care system. That's because, even if a state managed to raise adequate tax revenues to make up the shortfall, the resulting system would hardly qualify as a comprehensive indigent care system. It would not provide preventative care, mental health care, prenatal care, or primary care. It would only reimburse providers and hospitals for uncompensated care rendered to patients who come to their emergency rooms. If a state wished to provide, on its own, a more comprehensive health care program for its indigent population by following the Medicaid model, the revenue requirements to fund such a system would be even more extreme.

Therefore, if a state wanted to opt out of Medicaid and reestablish a comprehensive indigent care safety net for its residents, it would need to revert to a model resembling something like what existed prior to the advent of Medicaid. Experience has shown that such a system can be cost-effective and financially sustainable. It would rely on the ability of surrounding hospitals to refer patients into the publicly funded (or publicly contracted) system in accordance with their caseload requirements. But such a system is precluded by EMTALA, which expressly prohibits hospitals from transferring emergency patients for financial reasons.

EMTALA thus creates a sort of "Hotel California" relationship between the states and Medicaid: because most hospitals are financially bound to the program, the states can never leave the program. Even if a state's citizenry wanted to establish the most "bare-bones" indigent health care reimbursement system, such as that described above, EMTALA locks them inside the full Medicaid system unless they are willing and able to raise taxes to fully fund the slimmed-down program. The only other alternative that states have to Medicaid is to have no indigent health care system at all—and thus nothing to mitigate the losses EMTALA forces on their hospitals and providers. In the unlikely event that a state chose that option, the costs of EMTALA still would not dissipate.

By prohibiting patient transfers from high-cost facilities to lower-cost facilities for financial reasons, EMTALA obstructs both state governmental and nongovernmental innovations in the delivery of health care to indigent populations.

## COST-SHIFTING, CUTBACKS, AND DECREASED ACCESS TO CARE

The advent of EMTALA has contributed to the cost-shifting problem in health care. As hospitals and providers were compelled to render uncompensated care—and as it became common knowledge that such care was mandated—both hospitals and providers sought to pass some of their costs and lost revenues to the paying and insured population. However, prospective payment systems, diagnosis-related groups (a "one-size-fits-all" way of receiving Medicare reimbursement), and managed care programs have hindered hospitals' and physicians' abilities to continue this practice. According to a 1999 report released by the American College of Emergency Physicians Safety Net Task Force, the uncompensated costs to emergency physicians for services provided under EMTALA were estimated at $426 million in 1996 and the costs to hospitals for uncompensated inpatient care were a staggering $10 billion. More recently, as cited in a March 2011 *Wall Street Journal* op-ed by John Cogan, Glenn Hubbard, and Daniel Kessler, the cost-shifting directly resulting from EMTALA has been estimated to raise health insurance costs approximately 1.7 percent.

A much more damaging consequence of EMTALA is the fact that it has forced hospitals—particularly those serving low-income communities—to cut back on services or close their doors because of the large amount of uncompensated care. Many hospitals have ceased to offer obstetric services, closed trauma centers, made major cutbacks in equipment and staffing, and even shuttered their emergency departments to remain solvent. This internal form of cost-shifting has led to more crowded emergency rooms,

longer emergency room wait times, and loss of access to care. A 1991 General Accounting Office study cited the closure of 600 trauma centers nationwide in the preceding five years, leaving about 370 designated to provide trauma care. It reported, "Of the 15 trauma centers GAO reviewed, 15 have closed—12 primarily because of financial losses." A 1994 report revealed that since EMTALA's passage, over 700 hospitals that had ER and trauma services had ceased services because of overcrowding.

Hospitals have had increasing difficulty getting physicians to cover their emergency rooms, as doctors drop off emergency-call schedules because they are tired of rendering uncompensated care to people who might turn around and sue them for malpractice. Many hospitals have resorted to paying stipends to attract coverage of their emergency rooms, further straining their budgets. Those problems are magnified in regions of the country that have high populations of undocumented immigrants, who are almost always uninsured and have meager financial means. While all this might not technically qualify for the title of "cost-shifting," it is simply another way that society is paying the price for uncompensated care at hospitals, emergency rooms, and trauma centers.

## RECOMMENDATIONS

The simplest solution to the EMTALA problem is to repeal the legislation. Of course, critics will argue that repeal would result in an explosion in the number of indigent patients transferred in unstable conditions, only to die in transit or soon after arrival at the receiving hospitals. But such fears are unfounded.

It is important to remember there is no clear evidence that unstable transfers were occurring to any significant degree at the time of EMTALA's enactment. Most reports were anecdotal, and the few peer-reviewed studies on the matter were very limited in scope. As mentioned earlier, in 2001 the GAO stated that there were "no data on the incidence of patient dumping before [EMTALA's] enactment, and the only measure of current incidence—the number of confirmed violations—is imprecise." That same report stated that the "numbers of EMTALA violations and fines are relatively small, and hospitals are rarely terminated." Therefore, it is impossible to tell the size of the problem EMTALA was designed to remedy, as well as whether or not EMTALA has had a salutary effect.

Furthermore, local laws, practice standards, and civil remedies had long been in place to address the issues EMTALA targeted, and there is no evidence that such remedies were ineffective. Whatever effect EMTALA may or may not have had on decreasing unstable patient transfers, the deleterious effects are demonstrable and clear.

An alternative to complete repeal of EMTALA would be to amend the act so as to exempt hospitals in states that choose to opt out of Medicaid. States could then design indigent health care systems more compatible with local demographic and fiscal realities. Civil society would also be liberated to design flexible charitable health care systems consistent with local realities and community sensibilities.

The amendment approach would provide the nation with pilot programs, utilizing states that opt out of Medicaid as "laboratories of democracy." Not only could states opt out, but innovations in health care delivery to indigent populations would be possible and encouraged. Variations in design would be tested and compared. Policymakers could then compare patient outcomes between states that are in Medicaid and following EMTALA and states that have opted-out. The result would be a much more informed analysis of the benefits and risks of full EMTALA repeal.

## CONCLUSION

EMTALA is another example of Congress legislating in the midst of a news cycle, with disastrous unintended consequences. The unintended consequences include cost-shifting uncompensated care to patients with insurance, hospital cutbacks in services to the general public, hospital closures, crowded emergency rooms, longer emergency room wait times, shortages of physicians available to emergency patients, and an overall decrease in access to health care for the general population. In addition, the law impedes state sovereignty, trapping states in a federally managed indigent health care system. Finally, the law presents a barrier to innovation at the state and local level in the delivery of health care to indigent populations by governmental and nongovernmental organizations. *R*

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