



Health Matrix: The Journal of Law-Medicine

Volume 8 | Issue 1

1998

The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care

Lauren A. Dame

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>

 Part of the [Health Law and Policy Commons](#)

Recommended Citation

Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 Health Matrix 3 (1998)
Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol8/iss1/20>

This Symposium is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

ARTICLES

THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT: THE ANOMALOUS RIGHT TO HEALTH CARE

Lauren A. Dame†

INTRODUCTION

JUST OVER TEN YEARS AGO, Congress enacted the landmark piece of legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA). The idea behind the law is simple: no one who goes to a hospital emergency room seeking emergency medical care should be turned away or sent to another medical facility in an unstable condition because he cannot pay for care, or because he is otherwise considered an “undesirable” patient. Translating this simple idea into a statute, implementing regulations, and an enforce-

† Lauren Dame was the Staff Attorney/Health Care Researcher at Public Citizen’s Health Research Group in Washington, D.C., from March 1995 through December 1997. A.B., Stanford University, 1977; J.D., Harvard Law School, 1983; M.P.H., Harvard School of Public Health, 1992. Public Citizen’s Health Research Group is a consumer advocacy organization founded in 1971 by Ralph Nader and Dr. Sidney Wolfe to fight for the public’s health, and to give consumers more control over decisions that affect their health. Since 1991, the Health Research Group has studied the government enforcement of EMTALA, and has released a series of reports on the subject, including LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, HOSPITAL VIOLATIONS OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: A DETAILED LOOK AT “PATIENT DUMPING,” Dec. 1997; LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, PATIENT DUMPING IN HOSPITAL EMERGENCY ROOMS: AN UPDATE BASED ON COMPLAINTS RECEIVED BY HHS BETWEEN APRIL 1, 1994 AND MARCH 31, 1995, Mar. 1996; JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, UPDATE ON PATIENT DUMPING VIOLATIONS, Oct. 1994; JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, PATIENT DUMPING CONTINUES IN HOSPITAL EMERGENCY ROOMS, May 1993; JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, 140 HOSPITALS NAMED FOR PATIENT DUMPING VIOLATIONS, Apr. 1991.

ment scheme, however, has proven more difficult. On this occasion celebrating ten years of EMTALA, various stakeholders are still debating the meaning of some of the statute's most basic terminology, and government enforcement is episodic and variable. Adding to the debate are new twists created for the ten-year old law by major changes in the structure of the health care system and changes in health care financing, in particular, problems caused by the rapid growth of "managed care."¹

Some of the problems that EMTALA raises are those typical of any law — how to interpret legislative history, deal with ambiguous key words, and understand developing or changing case law. Yet more is in play here, for EMTALA establishes a right unique in the American health care system: a right to medical care without regard to ability to pay. Although this right is limited to stabilizing emergency care in hospital emergency rooms, it exists within a system where medical care is viewed as a commodity to be bought and sold like any other, and where medicine is becoming "big business." The contradiction between the right to emergency care created by EMTALA and a health care system heavily affected by issues of who pays and how much, is in large part responsible for the problems that have arisen in interpreting and enforcing EMTALA: the right created by EMTALA creates a conflict in our usual way of doing business. None of the participants in this Symposium seems to disagree that EMTALA creates a right that is anomalous in the American health care system; the disagreement arises over whether it is a good or bad thing.

In this Article, I look at EMTALA from a consumer's or patient's perspective.² In particular, I examine the

1. "Managed care" can be defined in a number of ways, but the key factor is that the financing of health care and the delivery of health care are linked in the same organization. This linkage alters the financial incentives that existed in traditional fee-for-service medicine, by creating incentives to reduce the amount of medical care provided and to limit patient access to expensive treatment locales, such as hospital emergency departments. The wide-spread shift from indemnity health insurance, which pays physicians on a fee-for-service basis, to systems of managed care, such as health maintenance organizations (HMOs), where physicians are often paid a flat fee to provide all needed medical care, is one of the most significant changes in the American health care system in the past decade. For a discussion of the problems consumers face under managed care, see generally Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 *HOU. L. REV.* 1319 (1996).

2. In this Article, I use the term "patient" to refer to the individual who comes to a

government's enforcement of the law, for although EMTALA provides for a private right of action, the population that has historically been most vulnerable to patient dumping is the poor and uninsured, a group of people often unlikely to have a lawyer to turn to when their rights are violated.³ Thus, if the government does not enforce EMTALA, or enforces it poorly, given the strong economic incentives of hospitals to "dump" patients, EMTALA's guarantees will be illusory.

Part I of the Article provides some background to the passage of the law by summarizing several research studies that looked at the nature and scope of the problem of "patient dumping" before EMTALA was passed. Part II provides a brief summary of the requirements that the law places upon hospitals. In Part III, the Article examines federal enforcement of EMTALA, including statistics about government enforcement activities obtained pursuant to Freedom of Information Act requests,⁴ and discusses some of the failings of government enforcement efforts. In Part IV, problems created by the rise of managed care are discussed, and Part V sets forth some concluding remarks.

hospital emergency room seeking emergency medical care. Although "patient" may be a somewhat ironic term to describe a person who is trying to become a patient and is being kept from doing so by the hospital, it is preferable to using the term "consumer," a word which suggests that one's rights hinge on one's ability to pay.

3. There is no question, however, that a lawsuit brought by a single patient can have an effect far beyond the facts of one case if it causes the hospital to change its procedures, or indeed, causes other hospitals to improve their treatment of patients. In this Article, I do not look at the case law that has evolved around EMTALA; however, there are a number of law review articles examining that case law. See, e.g., Melissa K. Stull, *Annotation: Construction and Application of Emergency Medical Treatment and Active Labor Act*, 104 A.L.R. FED. 166 (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); Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173 (1989); Mary Jean Fell, Comment, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 CATH. U. L. REV. 607 (1994); Amy J. McKittrick, Note, *The Effect of State Medical Malpractice Caps on Damages Awarded Under the Emergency Medical Treatment and Active Labor Act*, 42 CLEV. ST. L. REV. 171 (1994); Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOUS. L. REV. 113 (1996); Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121 (1992); Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463 (1996); Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After In the Matter of Baby K*, 48 VAND. L. REV. 1491 (1995).

4. See 5 U.S.C. § 552 (1994) (explaining the availability of and the mechanics of obtaining public information).

I. "PATIENT DUMPING" BEFORE EMTALA

Although patient dumping probably had been occurring in American hospitals for some time, it was not until the 1980s that the nature and scope of the problem was recognized.⁵ Several studies investigating patient dumping were published in medical journals, and two of the larger studies conducted at this time offer snapshots of what was happening in the nation's emergency rooms.⁶

The first of these two studies appeared in the May 1984 issue of the *American Journal of Public Health*, and examined patient transfers from fourteen private hospitals to the emergency room of a large public (county) hospital in Alameda County, California.⁷ Using the hospital's log, the researchers identified 458 patients who had been transferred from other hospitals to the county hospital's emergency department during a six-month period in 1981. Researchers looked at the insurance status of patients to analyze who was being transferred and at the health status of patients to determine whether the transfer had posed a risk. The answer to the question of who was being transferred was quite clear: it was the uninsured or those with government-funded insurance. Of the 458 patients transferred, sixty-three percent had no health insurance coverage, twenty-one percent had Medicaid, thirteen percent had Medicare, and only three percent had private health insurance.⁸

To determine whether the transfer had posed a risk to the patients' health, the researchers established criteria to identify patients who might have been endangered by the transfer. These included patients who, after transfer, were admitted to

5. See Robert L. Schiff & David Ansell, *Federal Anti-Patient-Dumping Provisions: The First Decade*, 28 ANNALS EMERGENCY MED. 77 (1996) (surveying the development of anti-patient-dumping provisions over the last ten years).

6. See, e.g., William Gary Reed et al., *The Effect of a Public Hospital's Transfer Policy on Patient Care*, 315 NEW ENG. J. MED. 1428, 1431 (1986) (discussing a study of patients transferred to Parkland Memorial Hospital in Dallas, Texas).

7. David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984) (finding that patient dumping in Alameda County, California endangered a significant number of affected poor, or minority, uninsured patients).

8. Medicare is a federal program that provides health insurance to people age 65 and over, and those who have permanent kidney failure, and certain people with disabilities; it covers more than 37 million Americans. Medicaid is a jointly funded, Federal-State health insurance program for certain low-income and needy people, and covers approximately 36 million individuals.

the county hospital's intensive care unit, operating room, or obstetrical unit, or patients who had been transferred with a stab wound, gunshot wound, fracture, dislocation, or injuries from a car accident. One hundred and eleven patients out of the 458 study patients met the "high risk" criteria, and charts for 103 of these patients were available for analysis. The study's classification procedures were conservative; each chart was reviewed by four physicians, and researchers categorized the transfer as "dangerous" if all four physicians "agreed that the patient was at risk of life-threatening complications in transit or that accepted practice would require immediate therapy that was delayed by the transfer."⁹ Borderline cases, and cases involving substandard care because of increased pain caused by delay and transfer, were not classified as dangerous. Based on this review, the researchers concluded that the transfer had been dangerous and had resulted in substandard care for almost a third of the patients.¹⁰

The researchers concluded that in the community they were studying, patients were commonly transferred from private to public hospital emergency rooms for financial or social reasons in spite of the fact that such transfers could endanger patients. They noted that the transfers primarily involved uninsured or government-insured patients, and disproportionately affected minority group members.¹¹

In another study, researchers reviewed 500 consecutive patient-transfers from Chicago area hospitals to Cook County Hospital, a public general hospital.¹² The researchers analyzed a number of variables, including the insurance status of the patients, the reasons given by the transferring hospitals for transfer, and the patients' health at the time of transfer. As in the

9. Himmelstein et al., *supra* note 7, at 495 (studying the effects of patient dumping over a six-month period in Alameda County, California).

10. When the researchers looked at the reasons given by the hospitals for transferring these 103 patients, only one had been transferred for a medical reason: to obtain services that were not available at the original hospital. *See id.* at 494-95.

11. Forty-five percent of the patients transferred were minority group members, while only 33% of the county's population was "non-White." *See id.* at 495-96.

12. Robert Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 *NEW ENG. J. MED.* 552, 552 (1986) (concluding that most patients are transferred to public hospitals because of economic reasons, despite the fact that many are in unstable conditions).

California study, they found that very few of the transfer patients had private health insurance: forty-six percent had no health insurance coverage; forty-six percent received public aid (including Medicaid); three percent received Medicare; four percent had private health insurance; and one percent had some miscellaneous coverage.¹³ The researchers examined the reasons for the transfer given by the transferring hospitals, and in eighty-seven percent of the cases where a reason was given, the reason was “lack of insurance.”¹⁴ Other reasons included “need for specialty care” (four percent), “lack of beds at the transferring hospital” (three percent), patient’s request (one percent), and “other” (five percent). They also found that the transfer process resulted in an average treatment delay of over five hours.

One of the study’s most serious findings was that almost a quarter of the patients had been medically “unstable” at the time of transfer.¹⁵ The researchers concluded with strong words about the implications of their findings:

[P]atients are transferred to Cook County Hospital from other hospital emergency departments predominantly for economic reasons. The fact that many patients are in a medically unstable condition at the time of transfer raises serious questions about the private health sector’s ability to consider the condition and well-being of patients objectively, given the strong economic incentives to transfer the uninsured. The delay in providing needed medical services as a result of the transfer process represents a serious limitation of the access to and quality of health care for the poor.¹⁶

Extrapolating from these studies and others, researchers estimated that as many as 250,000 patients a year in need of emergency care were being “dumped” — transferred from one hospital to another for economic reasons — by the late 1980s.¹⁷ The patient-dumping studies revealed the practice to

13. *See id.* at 553.

14. Interestingly, only 64% of the patients reported being given this reason for the transfer, indicating to the researchers that patients were not always told by hospitals the reasons they were being transferred, and that transfers were routinely occurring without informed consent. *See id.*

15. *See id.* at 554 (noting that a patient was judged to be medically “unstable” only if all four physicians reviewing the patient’s medical record concurred; if one physician disagreed, the patient would not be included as “unstable”).

16. *Id.* at 556.

17. *See* David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and*

be wide-spread, rather than isolated, and suggested that it had increased dramatically during the 1980s.¹⁸ The reasons for the increase in dumping could be found in changes that occurred in the health care system during this period. The number of uninsured Americans grew from twenty-five million uninsured in 1977 to thirty-five million in 1987, and there were large cut-backs in governmental funding of health programs.¹⁹ EMTALA could not solve or even address most of the problems that stemmed from these failures of the health care system, but it was enacted to prevent one of the most dramatic manifestations — sick or injured people being ejected from hospital emergency rooms because of their inability to pay.²⁰

II. THE REQUIREMENTS OF THE LAW

EMTALA was passed by Congress as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, and took effect on August 1, 1986.²¹ EMTALA requires a hospital to

Policy Recommendations, 257 JAMA 1500, 1500 (1987) (discussing the economic, ethical, legal, and medical aspects of patient dumping and suggesting solutions to the dumping problem).

18. Some urban areas with large increases in patient transfers during this period included Dallas (increased from 70 per month in 1982 to more than 200 per month in 1983); Washington, D.C. (increased from 169 per year in 1981 to 930 per year in 1985); and Chicago (increased from 1,295 per year in 1980 to 5,652 per year in 1984). *See id.* at 1500 (footnote omitted).

19. *See Schiff & Ansell, supra* note 5, at 77; Mary O. Mundinger, *Health Service Funding Cuts and the Declining Health of the Poor*, 313 NEW ENG. J. MED. 44, 47 (1985) (noting that 600,000 people were cut from Medicaid between 1981 and 1983).

20. The studies of patient dumping have focused on patients who were transferred from one hospital to another for economic reasons. EMTALA also protects patients who simply are turned away from a hospital emergency room or who are discharged in an unstable condition. *See* 42 U.S.C. 1395dd(a) and 42 U.S.C. 1395 dd(c)(1) (1997). However, it is harder to measure how often this occurs, since it is more difficult to study denials of care than to study transfers, where researchers can look at every transfer to a public hospital within a certain time period. Because of this, the information we have about patients being turned away from hospitals tends to appear as isolated stories in newspapers, and is criticized as “anecdotal.” While it is true that one should approach anecdotal evidence with caution, the fact that it is “anecdotal” does not necessarily mean that it is untrue, and sometimes it may be the only source of information we have.

21. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 164-67 (1986) (codified at 42 U.S.C. § 1395dd (1994)) (discussing examination and treatment for emergency medical conditions and women in labor). Because EMTALA was enacted as part of the Consolidated Omnibus Reconciliation Act, physicians and hospital personnel often refer to it as “the COBRA law,” and the COBRA imagery has been used in a variety of writings about EMTALA. *See, e.g.,* Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186 (1986) (reviewing the problem of patient dumping despite the enactment of COBRA anti-dumping legislation); American College of Emergency Physicians, Arkansas Chapter (visited Sep. 17 1997) <<http://www.alltel.net/~aracep/#cobra>> (“Like its namesake, COBRA is tricky and deadly . . . If

screen any individual who comes to the emergency department seeking medical care to determine whether the person has an emergency medical condition. If the individual has an emergency medical condition, the hospital must either *stabilize* the medical condition or *transfer* the person to another medical facility in accordance with the law's transfer requirements. These three requirements — provision of a screening exam, treatment to stabilize the medical condition, and appropriate transfer — form the core requirements of the statute. A hospital's failure to meet one or more of these constitutes a violation of the statute. The law was subsequently amended to add other requirements, such as a prohibition on delaying the screening exam in order to inquire about payment or insurance coverage;²² "whistle blower" protections, which prohibit the hospital from penalizing a physician who refuses to transfer an unstable patient or from taking action against a hospital employee who reports a violation of the law;²³ and a requirement that hospitals with specialized facilities, such as burn units or neonatal intensive care units, accept transfer patients needing specialized care.²⁴

While the law applies only to hospitals that participate in Medicare — the federal program that pays for medical care for the elderly and disabled — the protections of the law include any person who comes to the emergency room, not merely Medicare beneficiaries.²⁵ In addition, since almost all of the nation's hospitals are certified to receive Medicare funds, the law's reach is very broad.

A hospital that violates the law may lose its certification to participate in Medicare²⁶ and/or may be fined up to \$50,000 per violation.²⁷ Individual physicians who violate

you ever triage or transfer a patient out of your Emergency Department to another hospital, clinic or office, you need to understand COBRA/EMTALA.”). The use of the term COBRA can be confusing, however, because employers and workers use COBRA to refer to a different part of the Consolidated Omnibus Reconciliation Act of 1985 — Title X — which requires employers to continue providing health insurance benefits to former employees for a period of time following the end of employment.

22. See 42 U.S.C. § 1395dd(h) (1994).

23. See *id.* § 1395dd(i).

24. See *id.* § 1395dd(g).

25. See *id.* § 1395dd(a).

26. See 42 U.S.C.A. § 1395cc(b)(2) (West 1997).

27. See *id.* § 1395dd(d)(1)(A).

their obligations under the law may also be fined up to \$50,000 and, if the violation is "gross and flagrant" or is repeated, may be excluded from participation in Medicare.²⁸

In addition to the sanctions that may be imposed by the federal government, EMTALA provides for a private right of action for a person who is harmed as a direct result of a hospital's violation of EMTALA, permitting him/her to obtain damages and equitable relief.²⁹ A hospital that suffers a financial loss because of another hospital's failure to comply with EMTALA can bring suit to recover damages or to seek equitable relief.³⁰

III. GOVERNMENT ENFORCEMENT OF EMTALA

A. The Enforcement Process

The Department of Health and Human Services (HHS) is responsible for enforcing EMTALA. This duty is divided between two of its agencies: the Health Care Financing Administration (HCFA), the agency that runs the federal Medicare program; and the Office of the Inspector General (OIG), the office charged with promoting the efficiency, effectiveness, and integrity of HHS programs. The two agencies have different responsibilities in enforcement and different available techniques to discharge them: HCFA is responsible for Medicare terminations, and the OIG for imposing fines.

The HCFA enforcement process begins when one of HCFA's ten regional offices receives a complaint about an alleged EMTALA violation.³¹ The HCFA regional office re-

28. See *id.* § 1395dd(d)(1)(B).

29. See *id.* § 1395dd(d)(2)(A).

30. See *id.* § 1395dd(d)(2)(B) (1994) (defining the rights of medical facilities which have suffered financial losses under this section).

31. The Regional offices and the states that each encompasses are as follows: Region I (Boston) (includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); Region II (New York) (includes New Jersey, New York, Puerto Rico, Virgin Islands); Region III (Philadelphia) (includes Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia); Region IV (Atlanta) (includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee); Region V (Chicago) (includes Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin); Region VI (Dallas) (includes Arkansas, Louisiana, New Mexico, Oklahoma, Texas); Region VII (Kansas City) (includes Iowa, Kansas, Missouri, Nebraska); Region VIII (Denver) (includes Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming); Region IX (San Francisco) (includes Arizona, California, Hawaii, Nevada, Pacific

fers the matter to the appropriate state hospital licensing agency to conduct a survey of the hospital to gather information; the results are returned to the regional office for a determination as to whether a violation occurred. If the regional office determines that the hospital violated EMTALA, it sends it a notification letter and statement of deficiencies, giving the findings of the survey, and stating that the hospital will be terminated from participation with Medicare unless it submits a suitable "plan of correction." A hospital can escape termination from Medicare by demonstrating that it has corrected the problem that led to the violation, leading HCFA to "rescind" the proposed termination.³² HCFA then refers the case to the OIG for review to determine whether civil monetary penalties should be imposed.

When the OIG receives a case from HCFA, it first must have it reviewed by a state Peer Review Organization (PRO)³³ to determine whether the patient involved had an emergency medical condition that was not stabilized.³⁴ In conducting the review, the PRO meets with the hospital and physicians involved. In some cases, the PRO's conclusions lead the OIG to close the case. If not, the OIG must decide whether monetary penalties are appropriate and, if so, in what amount. In doing so, the OIG analyzes the PRO review and other information for evidence of a variety of aggravating and mitigating circumstances outlined in the statute, regulations, and case law implementing EMTALA.³⁵ Some of the factors to be considered

Islands); Region X (Seattle) (includes Alaska, Idaho, Oregon, Washington).

32. According to HCFA, a rescission of the termination decision means only that the termination proceeding will not go forth and the hospital will not lose its Medicare certification; it does not mean that HCFA has determined that no violation occurred. Telephone interview with Linda J. Spar, Senior Health Insurance Specialist, Center for Medicaid and State Operations, HCFA (Oct. 1, 1997).

33. PROs are state-level physician-sponsored organizations that contract with HCFA to ensure that Medicare beneficiaries receive care that is medically necessary, reasonable, and appropriate. PROs may also be consulted in cases of alleged EMTALA violations to evaluate medical care questions in the case.

34. This step is required before the OIG can impose a fine. *See* 42 U.S.C. § 1395dd(d)(3) (1994) (discussing consultations with peer review organizations).

35. *See* 42 U.S.C. § 1395dd(d)(1) (incorporating the standards set forth in section 1128A of the Social Security Act), 42 U.S.C. § 1320a-7a (1994), including 42 U.S.C. § 1320a-7a(d); 42 C.F.R. § 1003.106(a)(4) (1996) (explaining the factors the OIG considers in determining the penalty amount for EMTALA violations); *see also* *Burditt v. U.S. Department of Health and Human Services*, 934 F.2d 1362, 1375-76 (5th Cir. 1991) (upholding an ALJ's findings as to

include whether the hospital took corrective action, the financial condition of the hospital, the degree of culpability, and the nature and circumstances of the violation.

Most of the cases where a hospital ends up paying a civil monetary penalty are voluntarily settled by the OIG and the hospital (or physician), with the hospital (or physician) entering into a settlement agreement "to avoid the uncertainty and expense of litigation," but not admitting guilt.³⁶

B. Enforcement Statistics

In Fiscal Year (FY) 1987, the first year after the law took effect, HCFA conducted eighty-four investigations of "patient dumping" complaints and confirmed twenty-four violations.³⁷ In subsequent years, both the number of complaints investigated and the number of violations confirmed have increased steadily, yet they remain far below what might be expected given the estimates by researchers that as many as 250,000 economic transfers were taking place in the year before the law's passage.³⁸ According to HCFA data, a total of 1,850 investigations have been authorized from August 1986 through

aggravating and mitigating circumstances made pursuant to 42 C.F.R. § 1003.106(b)(5)).

36. The settlement agreements typically include a "No Admission of Liability" clause stating that "[t]his Agreement shall not be construed as an admission of liability or wrongdoing on the part of Respondent." (based on a review of OIG settlement agreements on file with author).

37. Unless otherwise indicated, the statistics used in this Article are based on the Public Citizen EMTALA database, which contains information from central HCFA, OIG, and HCFA regional offices. Since 1991, Public Citizen's Health Research Group has maintained a database of all confirmed violations of EMTALA and all OIG settlements, going back to the start of EMTALA enforcement. This database is based on HCFA's logs of Section 1867 cases (maintained by fiscal year), copies of settlements obtained from the OIG, and communications with regional OIG offices.

Once a regional office determines that a hospital has violated EMTALA, the regional office forwards the information to the central HCFA office, where it is entered into a log. These logs, as well as copies of any settlements, are obtained by Public Citizen from HHS pursuant to Freedom of Information Act requests. Because the central office logs are at times incorrect or incomplete, it has been a policy at Public Citizen to confirm with the regional offices all violations in their region. These communications with the regional offices have resulted in slight differences between the statistics maintained by HCFA and those by Public Citizen, but the differences are very small.

38. See Schiff & Ansell, *supra* note 5, at 77. Although one would expect the number of economically motivated transfers to drop significantly after the law made such transfers illegal, it seems unlikely that there would be such a dramatic drop in just one year, especially since there were no regulations implementing the law and hospitals were confused as to their exact obligations. A more probable explanation for the small number of cases investigated in the years following the law's passage is inadequate reporting and enforcement.

FY 1994, and 460 violations have been confirmed during this period.³⁹ The year-by-year statistics are detailed below in Table 1.

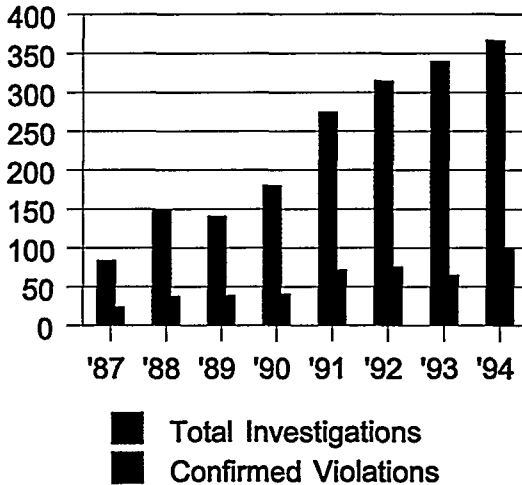
Fiscal Year	Number of Investigations	Number of Violations Confirmed	Percentage of Investigations with Confirmed Violations
1987	84	24	29%
1988	150	38	25%
1989	141	39	28%
1990	180	41	23%
1991	275	72	26%
1992	315	76	24%
1993	340	65	19%
1994	367	101	28%
Total	1,852	456	25%

The percentage of cases in which the investigation confirms a violation has ranged from approximately nineteen percent of the cases to twenty-nine percent of the cases, meaning that, on average, about one quarter of the complaints investigated by HCFA each year are found to involve a violation of the law. See Graph 1.

39. By September 30, 1996, HCFA had confirmed more than 800 violations. See LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, HOSPITAL VIOLATIONS OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT, Dec. 1997, at 3.

Patient Dumping Investigations

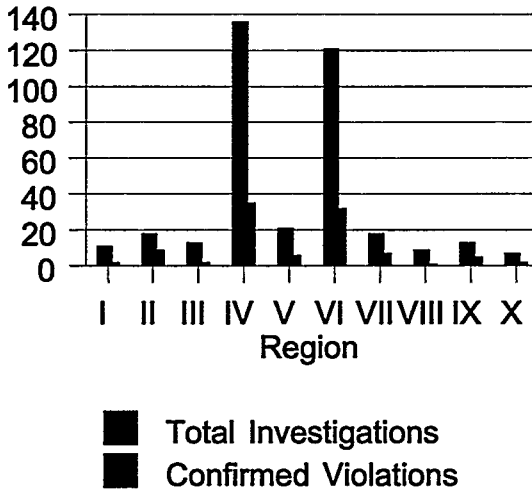
Fiscal Years 1987 - 1994



Interestingly, there is great variation in enforcement activity in different parts of the country. Every year since 1987, Region IV (headquartered in Atlanta) and Region VI (headquartered in Dallas) have led the nation in the number of cases investigated and violations confirmed. In FY 1994, these two regions accounted for seventy percent of the investigations and sixty-six percent of the confirmed violations nationwide. It is not clear why there is such great regional variation in EMTALA enforcement activity. While the variation could be due to different levels of illegal dumping activity, there is no strong evidence to support this notion. It seems likely that the differences are a result of a combination of factors, including differences in the federal government's enforcement practices in different parts of the country and substantial under-reporting in some regions. Graph 2 shows the regional variation for FY 1994, the most recent year for which complete data are available.

Regional Variation

Fiscal Year 1994



Although most of the hospitals that violate the law are placed on a “termination track” by HCFA, only a rare few are actually terminated from Medicare participation. Since 1986, HCFA has terminated only six hospitals from Medicare participation because of EMTALA violations, and four of them were later recertified. In addition, three other hospitals agreed to “voluntary terminations” and withdrew from Medicare, and four others closed before alleged dumping violations could be confirmed.⁴⁰

As described earlier, once HCFA confirms a violation, it refers the case to the OIG to determine whether fines are warranted. From 1987 through 1996, the OIG negotiated settlements with fifty-eight hospitals and twelve physicians, impos-

40. See JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UPDATE ON “PATIENT DUMPING” VIOLATIONS, Oct. 1994, at 10; PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, PATIENT DUMPING CONTINUES IN HOSPITAL EMERGENCY ROOMS, May 1993, at T-2. In October 1996, a California hospital that had been cited for two dumping violations was scheduled to be terminated when it won a last-minute reprieve from HCFA. According to one hospital official, loss of Medicare certification would have resulted in closure of the hospital within six months. See *Southern California Hospital Avoids Loss of Medicare Certification*, 7 BNA MEDICARE REP. 1267 (1996).

ing fines in all of these settlements ranging from a low of \$1,500 to a high of \$150,000. The OIG's enforcement has increased in recent years, with the number of fines imposed in 1994 twice that imposed in 1993, yet in absolute terms, the number of cases that result in fines is very small. See Table 2, below.

Year	Number of Settlements (Hospitals)	Number of Settlements (Physicians)	Range of Settlement Amount	
			Low	High
1987	2	0	\$5,000	\$100,000
1988	3	0	\$5,000	\$20,000
1989	2	0	\$10,000	\$100,500
1990	5	2	\$7,500	\$150,000
1991	3	0	\$1,500	\$40,000
1992	2	1	\$30,000	\$30,000
1993	5	1	\$5,000	\$30,000
1994	10	0	\$2,500	\$40,000
1995	9	7	\$2,500	\$45,000
1996	17	1	\$5,000	\$55,000
Total	58	12		

C. Criticism of Government Enforcement

It is clear from these statistics that very few hospitals that violate EMTALA are actually punished, either by termination from Medicare or by the imposition of a fine. Of the more than 800 EMTALA violations confirmed between 1986 and September 1996, only sixty-seven hospitals were punished (nine hospitals terminated/withdrew and fifty-eight were fined).⁴¹ Put

41. These figures are based on HCFA data through September 1996, and OIG settlement information through 1996. See LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH

another way, more than ninety percent of hospitals with confirmed EMTALA violations escape punishment completely. Further, the public is usually unaware that a hospital violated the law because HCFA does not publish a "notice of proposed termination" unless the hospital fails to take corrective action before the end of the termination process.⁴² By taking corrective action within the given time frame, the hospital may avoid any public notice of the violation.

One reason for the relative dearth of penalties is that enforcement of the law by the federal government has been inadequate. The failure of enforcement takes a number of forms. A major problem was the lengthy delay by HCFA in publishing final regulations to implement the law. Proposed regulations were published in 1988,⁴³ but final regulations were not published until June 1994, some six years later.⁴⁴ During this entire period, there were no regulations implementing EMTALA's mandate. One of the most serious effects of this hiatus was that hospitals receiving "dumped" patients were not required to report those illegal transfers to the government. The reluctance of hospitals to report other hospitals had the effect of depriving the government of its best source of information. Until the hospital reporting requirement became effective in September 1995, the government had to rely on voluntary complaints from patients, families, hospital workers, and others to uncover patient-dumping violations.⁴⁵

The reporting requirement, on the other hand, would help ensure that the party most likely to be aware of an illegal transfer — the receiving hospital — would inform HCFA of

RESEARCH GROUP, HOSPITAL VIOLATIONS OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT, Dec. 1997.

42. See generally 42 C.F.R. § 489.53 (1996) (establishing the process of notice of termination to the medical provider and to the public by HCFA).

43. 53 Fed. Reg. 22513 (1988).

44. 59 Fed. Reg. 32086 (1994).

45. 42 C.F.R. § 489.20(m) (1996) (requiring a Medicare participating hospital to notify HCFA "any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the [law's transfer] requirements"). Although most of the final regulations took effect in July 1994, the reporting provision had to be cleared by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (Pub.L. No. 104-13, 109 Stat. 1995, codified at 44 U.S.C.A. § 101 (West 1995)) because it imposed paperwork obligations on hospitals. The OMB process took over a year, so the reporting provision did not take effect until September 1995.

the event. It is hoped that the reporting requirement will increase the discovery of illegal patient transfers, but how vigorously HCFA will enforce this requirement remains to be seen. If HCFA rarely terminates hospitals even for illegally transferring patients, it seems unlikely that it will terminate hospitals for failing to report an illegal transfer.

A second problem that has hindered enforcement of the law has been the lack of coordination between HCFA and the OIG. The division of enforcement responsibility between the two agencies has been a source of difficulty from the beginning, with hospitals complaining about having to respond to multiple investigations, and even the government's own analysts have found serious problems. In a 1988 report by the OIG's Office of Analysis and Inspections, the authors found that coordination between HCFA and the OIG has not been a priority, and concluded that HHS should better align the responsibilities of its various agencies in order to provide a unified response to each patient-dumping complaint. The report pointed out that to do otherwise resulted in "duplicative efforts, inefficient expenditure of resources, inconsistent responses, and a lengthened response time."⁴⁶ This recommended realignment, however, has never taken place, although there has been better coordination between the two offices, and the OIG is a participant in a HCFA-sponsored work group on EMTALA.⁴⁷

There has been one modest improvement in referrals of cases by HCFA to the OIG. Prior to October 1994, the HCFA regional offices would refer some, but not all cases involving violations to the local OIG field office, where the cases might be closed or sent on to OIG headquarters in Washington, D.C. Beginning in October 1994, this policy was changed, and now HCFA regional offices send all cases of confirmed violations to the OIG Office of Civil Fraud and Administrative Adjudication in Washington, D.C. While the effect of this change is still unclear, there is now a centralized review of all the cases,

46. Office of Analysis and Inspections, Office of Inspector General, *PATIENT DUMPING AFTER COBRA: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSE TO COMPLAINTS*, ii (Nov. 1988) (recommending that HHS align the responsibilities of its component agencies in order to assure a unified response to complaints about patient dumping).

47. See generally Joan Stieber & Linda J. Spar, *EMTALA in the '90s — Enforcement Challenges*, 8 *HEALTH MATRIX* 57 (1998).

which may help the OIG discern trends in violations and ensure greater consistency in enforcement.

A third problem with the government's enforcement has been its failure to use what may be one of the most effective sanctions it has available to it: publicity. As mentioned previously, it is only when a hospital fails to take corrective action by the final days of the termination track that a notice is published by HCFA, and therefore, it is relatively easy for hospitals to avoid this public notice provided they can take corrective action before the end of the termination period. It would be more appropriate for public notice to be made of all confirmed violations, a notice which could include information about any corrective action taken. For most hospitals, reputation in the community is of vital importance. Fear of bad publicity might prove a more effective deterrent to dumping than the relatively small monetary fines the OIG occasionally imposes. In addition, publicity of violations would serve to educate patients as to their rights under the law.

HCFA could also increase publicity of EMTALA violations by making information about confirmed violations easier for interested parties to obtain,⁴⁸ and by compiling the information in more user-friendly formats.⁴⁹ Such information might be of particular interest to community activists or hospital trustees trying to evaluate a proposed merger or acquisition of a local hospital by another hospital (or hospital chain). The hospital industry is undergoing a rapid transformation today, and deals are often proposed and finalized with little time for the public to obtain information for evaluating the deal.⁵⁰ That

48. HCFA has taken some action on this point: until August 1995, an FOIA request to HCFA was required to obtain the HCFA central logs listing EMTALA violations, and it took HCFA from six to nine months to fulfill such requests. Such a lengthy lead time obviously would be discouraging for news reporters trying to meet a deadline. As of August 15, 1995, the HCFA FOI Privacy Office granted authority to the Health Standards and Quality Bureau to release the logs directly in response to requests from the public. This policy change has reduced the request time to as little as two weeks. (Letter from Kathy Pirote, Health Standards and Quality Bureau, Sept. 29, 1995) (on file with author).

49. The central HCFA logs list the date a complaint was received by HCFA, the hospital's name, city, state, a one-word description of the violation (i.e., "screening" or "transfer," etc.) the dates of surveys, projected termination date, and resolution. While the logs are useful for raw statistics, they provide little detail and are often incomplete.

50. See, e.g., Sandy Lutz, 1995: *A Record Year of Hospital Deals*, MOD. HEALTHCARE, Dec. 18-25, 1995, at 43 (reporting that there were 230 hospital mergers or acquisitions in 1995).

a would-be acquiring hospital has a record of several EMTALA violations reveals something about the hospital's attentiveness to charity care.⁵¹

The OIG might also make better use of publicity when concluding its investigations. In the years before 1993, the settlements negotiated by the OIG routinely included non-disclosure clauses where the government agreed not to publicize the case affirmatively.⁵² The government discontinued the secrecy policy in 1992, and current OIG policy is to include a community outreach provision in all settlements with hospitals. The outreach provision typically requires the hospital to run ads in local newspapers notifying the public that the hospital's emergency room is open to all members of the community, regardless of ability to pay.⁵³ These ads, however, fall short of the type of disclosure needed: they do not inform the public that the hospital was being investigated for an alleged EMTALA violation, neither do they clearly describe patients' rights under the law, nor how a person who is illegally dumped should file a complaint.

compared to 184 deals in 1994, and that approximately one in five U.S. community hospitals changed hands in the last two years); *see generally* MARY GABAY & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, WHO CONTROLS THE LOCAL HOSPITAL? THE CURRENT HOSPITAL MERGER AND ACQUISITION CRAZE AND THE DISTURBING TREND OF NOT-FOR-PROFIT HOSPITAL CONVERSIONS TO FOR-PROFIT STATUS, June 1996, at 18.

51. Cf. LAUREN A. DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UPDATE: PATIENT DUMPING IN HOSPITAL EMERGENCY ROOMS, Mar. 1996, at 2 (reporting that during the period covered by this report, for-profit hospitals were more likely than not-for-profit hospitals to violate EMTALA).

52. Of the seventeen settlement agreements with hospitals concluded from 1986 through 1992, ten contained secrecy clauses. *See* JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, PATIENT DUMPING CONTINUES IN HOSPITAL EMERGENCY ROOMS, at Table 6, May 1993.

53. All but one of the twenty-six settlement agreements with hospitals executed in 1995 and 1996 contained a community outreach provision similar to this: "Respondent agrees to affirmatively make it known in its service area that it is a Medicare and Medicaid participating hospital, and that its emergency room is available to examine all people in the community who come to the emergency room to determine if they have an emergency medical condition, regardless of ability to pay and without delay to inquire about insurance status. The Respondent will meet this obligation by publishing an advertisement in the [local newspaper] twice: within six months of and once within twelve months of the execution of this agreement." (from copies of 1995 and 1996 OIG settlement agreements, on file with author).

IV. EMTALA AND MANAGED CARE — NEW PROBLEMS

Concerns about EMTALA have intensified in recent years because of a new source of conflict in the emergency room, one unanticipated when EMTALA was enacted — managed care. When EMTALA was enacted, the American health care system was a different world than what it is today. Few Americans received their health care from managed care organizations, and most insured people had coverage in which the insurer did not tell them when or where they could receive their medical care. If they went to a hospital emergency room, the insurance company did not expect the emergency physician to call to discuss the proposed treatment. Today, the situation is reversed, with the vast majority of insured Americans being covered by some sort of managed care organization, and these managed care patients are running into problems when they seek care in a hospital emergency room.

Managed care organizations attempt to control costs by directing patients to the least expensive location for treatment and by requiring that expensive tests, procedures, and treatments be “pre-authorized.” These cost-control techniques do not mesh well, however, with the needs of emergency medicine, where injured, sick, and hurting patients often need care quickly, during “non-business hours,” and without complicated authorization roadblocks. Members of HMOs, who pay monthly premiums for their health insurance, and who expect that their emergency care will be covered, are running into problems when they seek emergency care at a hospital that does not have a contract with their HMO, or when they fail to obtain some required pre-authorization.⁵⁴ The problems include being directed away from a nearby hospital to one further away, being transferred from one hospital to another in an unstable condition, and receiving care but later having to pay for the care that the HMO denied. Even though HMO contracts typically cover “emergency care” wherever it is provided, patients

54. For an excellent discussion of the problems of emergency care and managed care in general, see Diane E. Hoffmann, *Emergency Care and Managed Care — A Dangerous Combination*, 72 WASH. L. REV. 315 (1997).

often find that their HMO defines “emergency” differently than they do. Many HMOs decide whether an emergency existed based on an after-the-fact review of events, and if in hindsight it appears that the problem was not a true emergency, the HMO may deny payment for the hospital services, leaving either the consumer or the hospital stuck with the bill.⁵⁵ The fear that their medical bills might not be covered by their insurance may keep HMO members who need emergency care from going to the hospital when they should.

The idea that a patient experiencing an emergency medical condition would not seek care because of fear of receiving a large medical bill is not merely theoretical. In a 1994 study in California, researchers analyzed what happened when HMO patients came to a university hospital emergency department and calls seeking authorization for treatment were made to the HMOs. They found that of the 545 patients for whom authorization for emergency care was denied by their HMO, ninety-five percent left the emergency department without receiving treatment. The researchers found this disturbing, and noted that “[t]hese patients left [against medical advice] despite the fact that [they] had hands-on evaluations by a trained registered nurse who determined that they needed evaluation for emergency conditions.”⁵⁶

Ironically, one of the reasons HMOs can get away with this conduct is EMTALA. They know that if one of their members shows up at an emergency room, the hospital is required by EMTALA to provide a screening exam and to stabilize the patient — even if there has been no commitment by the HMO to pay. The HMO can err on the side of denying emergency room authorization because the risk of turning away a patient

55. An example would be a situation where a middle-aged man experiences chest pains in the middle of the night and goes to the nearest hospital thinking that he is having a heart attack. After a number of diagnostic tests, the emergency room doctor concludes that the man has “heartburn” or indigestion. Since “heartburn” is not an emergency, the HMO then denies payment for the hospital services.

56. Robert W. Derlet & Bridget Hamilton, *The Impact of Health Maintenance Organization Care Authorization Policy on an Emergency Department Before California’s New Managed Care Law*, 3 ACAD. EMERGENCY MED. 338, 342 (1996). Since the study was conducted, a new California law took effect, which prohibits HMOs from requiring emergency departments to make authorization calls prior to treatment and stabilization. CAL. HEALTH & SAFETY CODE § 1371.4(a) (West 1997).

with an unstable medical condition falls on the hospital and emergency physician, not on the HMO.⁵⁷ While statistics about the frequency of this practice are difficult to obtain since private HMOs are not required to collect or reveal such incidents, there are a number of indications that the problem is serious and widespread.⁵⁸ Dr. Larry Bedard, President of the American College of Emergency Physicians, an organization that represents 19,000 emergency physicians, argues that “the widespread and all-too-routine denial of emergency care claims by managed care companies as they attempt to minimize expenditures” is creating a serious “situation that puts the health and even the lives of people at risk everyday in emergency

57. A “medical management bulletin” from a California managed care organization to its network physicians, obtained by Public Citizen, embodies this thinking:

EMERGENCY TREATMENT AUTHORIZATION

[NETWORK] physicians are frequently contacted by hospital emergency departments (E.D.) seeking “authorization” for a patient that has presented to the E.D. for evaluation and/or treatment. The exact definition of a medical emergency varies by HMO, but all have certain things in common. The presenting condition must be threatening to life or limb, likely to result in permanent disability, or include severe pain, and the appearance of the illness or injury must be unforeseen.

[NETWORK] recommends that, when you take a call from an emergency department requesting authorization to see one of your patients (or one for whom you are on call), and you are concerned that the condition does not meet the above definition, give the following response:

“Authorization is not being granted for the visit. The claim will be reviewed later, and will be paid if retrospective analysis shows that the care was for a bona fide emergency.”

With this response, the E.D. is required by law to evaluate the patient and treat if medically indicated. [NETWORK] will pay for care given if a genuine emergency existed, but will be able to deny the claim if it was for a non-emergency situation. The emergency department will ask the patient to sign a waiver informing the patient that he/she will be financially responsible if upon review a genuine emergency was not found to have existed.

\$1,000,000 of your [NETWORK] dollars a year are at stake — thank you for your cooperation.

(March 11, 1993) (on file with author).

58. For example, in 1996, PacifiCare, an Oregon HMO, was fined \$20,000 by the state for “a consistent pattern” of denying emergency room claims without making enough of an effort to determine if the claims were proper. Between 1992 and 1994, the period examined by the state’s Department of Consumer and Business Services’ Insurance Division, PacifiCare denied twenty-three percent of its emergency room claims, and thirteen percent of these denials were appealed. Of those appealed, the HMO ended up reversing the denials in seventy-eight of the cases. See *MANAGED CARE WK.*, no. 5, Jan. 29, 1996; 4 *WASH. HEALTH WK.*, no. 9, Jan. 29, 1996. See also Diane E. Hoffman, *Emergency Care and Managed Care — A Dangerous Combination*, 72 *WASH. L. REV.*, at 332-34 (discussing small-scale studies suggesting that the practice of HMOs routinely denying emergency room claims is widespread).

departments across the country.”⁵⁹ He goes on to explain the nature of the problem:

Managed care has been unable to deal with the fact that emergency care is not the predictable, orderly practice of medicine that is the hallmark of managed care. Emergency services are often provided in dramatic situations that demand fast and knowledgeable decision-making. Unfortunately, managed care has been unwilling to accept the fact that emergency care demands a different standard of flexibility.⁶⁰

The two philosophies were bound to conflict, but the conflict has been highlighted by EMTALA. The solution that has been proposed by many concerned with this problem is to require HMOs to apply a “prudent layperson” standard in determining whether a medical emergency existed. Under such a standard, the HMO would have to look at the situation from the point of view of the patient at the time he sought care, and if a prudent layperson would have reasonably thought that he was experiencing a medical emergency, the HMO would have to cover the treatment.⁶¹ It is hard to deny the fairness of such an approach: it balances the HMO’s desire to keep patients who are clearly not having an emergency out of expensive hospital emergency rooms, while providing the appropriate margin of error for a person who is injured, sick, or in pain, and who has to decide whether to seek emergency medical care. Such a rule is needed to replace the unfair determination made by HMOs in the calm aftermath of the events. While there are some

59. *Subcommittee on Consumer Rights, Protections, and Responsibilities of the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry* (June 25, 1997) (Testimony of Dr. Larry Bedard, President, American College of Emergency Physicians).

60. *Id.* at 6.

61. The prudent layperson definition of an emergency medical condition has been adopted in a number of states. *See, e.g.*, Maryland (MD. CODE ANN., HEALTH-GEN. § 19-701(d) (1996)); New York, (N.Y. INS. LAW § 3216(1)(9) (Consol. 1997)); Virginia (VA. CODE ANN. § 38.2-4300 (Michie 1950 & Supp. 1997)) (mandating that basic health services include out-of-area emergency care and stating that a medical emergency is a medical condition thought by a prudent layperson to result in serious consequences without treatment); Arkansas (ARK. CODE ANN. § 20-9-309(c)(1) (Michie 1995)) (discussing the definition of emergency medical care); Georgia (GA. CODE ANN. §§ 33-20A-3, 33-20A-9 (Supp. 1997)); and is under consideration in a number of others. At the federal level, a prudent layperson standard is part of legislation introduced by Rep. Ben Cardin (D-MD); *see* H.R. 815, 105th Cong. (The Access to Emergency Medical Services Act of 1997). In addition, President Clinton’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry has endorsed the prudent layperson standard for emergency room visits as part of the Commission’s proposed Patients’ Bill of Rights. Eric Weissenstein, *Quality Panel Outlines Patient “Bill of Rights,”* 27 MOD. HEALTHCARE 30 (1997).

medical problems that are clearly not emergencies, and others no one would doubt were emergencies, there will always be a gray area in between, and even physicians are not always able to judge whether an emergency exists. Coverage decisions should be based on presenting symptoms, not on the ultimate diagnosis.

V. CONCLUSIONS

When EMTALA was passed in 1986, it was a response to the appalling fact that in one of the wealthiest nations of the world, seriously ill or injured people were being shuffled from one hospital to another, or turned away from hospitals altogether, because they were poor and could not pay for care. The law's focus is narrow — it helps only those who go to an emergency room, and then requires care only if it is necessary to stabilize an emergency medical condition. But within this narrow focus, the law is absolute in its principle that no one needing emergency medical care will be turned away, and that the government will ensure that this right is protected. The government's enforcement, however, has not been as vigorous as it should be: it rarely penalizes hospitals that violate the law as long as they agree to come into compliance; it rarely imposes civil monetary fines, and when it does, the amounts are often low; it enforces the act inconsistently across the country; and it took years to issue final regulations implementing the law. However, over the past few years, the government's enforcement has improved, and it is hoped that this will continue. For in spite of past weaknesses in enforcement, EMTALA is an essential source of protection for people needing emergency medical care. The law provides a clear expression of federal policy that it is not acceptable for hospitals to transfer patients in unstable emergency conditions to other hospitals for purely economic reasons, or to refuse to care for people who come to their doors needing emergency care.

Many view the dumping of uninsured patients to be a problem of the past, and it is true that as hospitals and physicians have become more familiar with EMTALA, and as patients have become more aware of their rights under the law, the flagrant violations have diminished. Complacency is un-

warranted, however, for the health care system failures that in the 1980s led to increased patient dumping are still with us today: growing numbers of uninsured and underinsured, reductions in Medicaid coverage for the poor, and financial pressures on hospitals to focus on the "bottom-line." In 1987, the first year of EMTALA, approximately thirty-five million Americans lacked health insurance; today, an estimated forty-three to forty-four million have no insurance.⁶² It is important, therefore, to continue to seek vigorous government enforcement of this law.

The growth of managed care has made EMTALA a pressing topic for emergency physicians who find themselves caught daily between the demands of managed care medicine, on the one hand, and the requirements of EMTALA on the other. The burden of these conflicting pressures is one reason why organizations such as the American College of Emergency Physicians are pushing for federal legislation to impose a "prudent layperson" standard on managed care organizations and to prohibit pre-authorization requirements and other HMO-tactics. Support for such legislation appears strong, and no doubt some version of a federal "prudent layperson" standard will ultimately be enacted to resolve the difficulties that doctors and patients are having in the emergency department today. While resolving this particular set of problems is no small matter to thousands of HMO patients and the emergency physicians who care for them, the legislation will not take care of the real problem, of which the HMO difficulties are but symptoms. For the problem with the American health care system is that it is not a system at all. The population increasingly is divided into different groups for insurance purposes; the sick, poor, and chronically ill have trouble getting insurance coverage at all; and medical decisions are being made more and more by managers at insurance companies and managed care organizations, instead of by physicians.

62. See Agency for Health Care Policy and Research (AHCPR), *The Uninsured in America: 1996 Health Insurance Status of the U.S. Civilian Noninstitutionalized Population* (visited Sept. 26, 1997) <<http://www.meps.ahcpr.gov/highlit/mephigh1.htm>> (discussing the Medical Expenditure Panel Survey).

At the beginning of this Article, I pointed out that all of the participants in this Symposium agreed that EMTALA gave patients a right to medical care that was an anomaly in our American health care system. Not only is this right an anomaly, it is possible to argue, as some of the participants in this Symposium do, that the right is actually irrational; we will pay for expensive emergency room treatment of a medical condition, but not provide the cheaper, basic medical care that so many need, and that in some circumstances, might obviate the need for emergency treatment. And indeed, if one assumes that the baseline for assessing the American medical system is our current enfeebled level of entitlement and skewed distribution of medical care, EMTALA does look irrational. Yet such a method has little to recommend it, indeed it works exactly backwards: the purpose of EMTALA, to protect patients at a time of scary and perhaps desperate medical need, is noble and reflects the finer aspects of our medical system. Any irrationality that arises is not because of flaws in the language of the statute, or failure of the regulations, but because of flaws in our overall health care system. As long as tens of millions of Americans remain uninsured, and medical decisions are driven by concerns about who pays the bills, patients will continue to have trouble in emergency rooms and elsewhere: what is needed is true health care reform that provides universal health care coverage. In such a system, where everyone was entitled to basic medical care without regard to ability to pay, there would be little reason for hospital emergency rooms to shuffle around patients for non-medical reasons. In such a system, EMTALA would no longer be an anomaly, and indeed, the need for EMTALA should disappear altogether. Rather than assessing EMTALA against the impoverished entitlements of the rest of our medical system, we should reverse the process. Judged against the basic norm that EMTALA represents — people in need should have a right to medical care — it is our medical system and not EMTALA that is irrational.