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EMTALA IN THE '90S — ENFORCEMENT CHALLENGES

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I. INTRODUCTION

ANY DISCUSSION OF THE FEDERAL LAW passed by Congress in 1986¹ to ensure universal access to emergency medical care must first consider the question of nomenclature, or what to call the subject of this symposium. While consumer advocates favor the term “patient dumping,” bureaucrats may find it a bit inflammatory. The more neutral “anti-dumping” is a possible candidate, but may be mistaken for a reference to the disposal of toxic waste. Many academics know the issue by the acronym COBRA (for the Consolidated Omnibus Budget Reconciliation Act of 1985, of which it was a tiny part), which lends itself to catchy titles for law review articles like *Sharpening the COBRA's Fangs*.² But most people associate COBRA with the extension of health insurance after leaving one's job — a more popular provision of the same lengthy budget bill.³ The last option, EMTALA, is used in the name of this

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1. While the Emergency Medical Treatment and Labor Act (EMTALA) was included in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), it was actually passed by Congress in April, 1986.

2. See Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986); Timothy H. Bosler & Patrick M. Davis, *Is EMTALA a Defanged COBRA?*, 51 J. Mo. B. 165 (1995).

3. Consolidated Omnibus Budget Reconciliation Act of 1985 § 10001, 42 U.S.C.A.

symposium and we have, therefore, adopted it in our discussion below. However, even this acronym is not problem-free. It is commonly believed to stand for the "Emergency Medical Treatment and *Active* Labor Act" — the original name of the original bill, which became Section 1867 of the Social Security Act.⁴ In fact, the word "active" was subsequently deleted from the law,⁵ since no one could figure out the *legal* difference between "active labor" and garden-variety "labor." Fortunately the acronym EMTALA still works and is in vogue today.

Few aspects of health law have generated as much public attention or emotional debate as EMTALA, which is still a source of controversy after over a decade on the books. Several factors may account for its unique position in the public eye. First: it is about people in crisis, in the midst of acute medical emergencies who, without immediate treatment, may be seriously disabled or die. Second: it deals with a fundamental issue in our health care system — whether access will be driven by concern about who pays the bill. The need for this law is demonstrated by over forty million people who are uninsured,⁶ and by the perception that a large amount of "uncompensated care" enters the hospital through the emergency department. Third: it represents a narrow exception to the general rule that we, in this country, do not recognize a right to health care. But in 1986, Congress decided that it would be unconscionable to deny treatment to people with life-threatening medical emergencies either because they are unable to pay or for any other reason unrelated to a hospital's ability to provide such care.⁷

§ 300bb-2(2) (West 1997) (stating that health insurance coverage may be extended 18 months from the date of a qualifying event including employment termination and death or divorce of a covered employee).

4. Social Security Act § 1867, *codified at* 42 U.S.C. § 1395dd. *See also* 42 U.S.C.A. § 1395cc(a)(1)(I), (N) (West 1997) (describing additional requirements of a participating hospital or rural primary care hospital).

5. *See* The Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h)(2), 103 Stat. 2106, 42 U.S.C.A. § 1395dd (West 1997) (eliminating all references to the term "active" in describing labor).

6. *See, e.g.*, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, 105TH CONG., MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO THE CONGRESS, at 29 (1997) (reporting that the uninsured population rose from 32 million to 40 million between 1988 and 1995).

7. *See, e.g.*, House of Representatives, 100th Cong., Press Release (announcing hearing on EMTALA before the Human Resources and Intergovernmental Relations Subcomm., Comm. on Government Operations, and quoting Rep. Ted Weiss who stated that "[t]ransfer of sick or injured

This Article is based on remarks presented at a symposium commemorating the tenth anniversary of EMTALA, from the perspective of the Health Care Financing Administration (HCFA) — the government agency charged with primary enforcement of the law. Unlike most of HCFA's mission, focused on Medicare and Medicaid,⁸ EMTALA transcends any one payment source or patient population to reach *all* patients who come to a hospital seeking emergency medical care. This discussion will provide a brief overview of the law's primary requirements, public and private enforcement mechanisms, regulations promulgated by HCFA, and a recent work group convened to recommend changes to the agency's EMTALA policies and enforcement procedures. It will also discuss new challenges raised by EMTALA in the current health care environment and legislative strategies considered by Congress to address perceived gaps in the law.

II. BASICS OF THE LAW — EMTALA 101

A. Basic Requirements

EMTALA applies only to hospitals that participate in Medicare⁹ (which is almost all hospitals) and that offer emergency services.¹⁰ However, it applies to all patients who come

persons or women in labor from one hospital emergency room to another because they are uninsured or on Medicaid is a form of social triage that is absolutely unacceptable in a civilized society") (on file with author).

8. Medicare, authorized in 1965 under Title XVIII of the Social Security Act, is a federal health insurance program for the elderly and disabled. Medicaid, authorized by Title XIX of the Social Security Act, provides health insurance for low-income persons and is jointly administered by the federal government and the States. These programs together provide access to health care for over 70 million people, or one in four Americans. The Health Care Financing Administration, a component of the U.S. Department of Health and Human Services, is delegated responsibility for administering Medicare and the federal portion of Medicaid.

9. See 42 U.S.C.A. § 1395dd(e)(2) (West 1997) (stating that a participating hospital is a hospital that has entered into a provider agreement pursuant to 42 U.S.C.A. § 1395cc).

10. See *id.* § 1395dd(a) This subsection of the statute states that the medical screening requirement applies to "a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department . . ." However, subsection (b) states that stabilizing treatment must be provided "[i]f any individual . . . comes to the hospital and the hospital determines that the individual has an emergency medical condition, . . ." 42 U.S.C.A. § 1395dd(b) (1997). This inexact drafting led to some initial confusion about whether the law applied only to hospitals with a formal "emergency department" or whether it applied more broadly to any hospital that held itself out to the community as offering emergency services. In support of the latter interpretation, HCFA noted that Congress did not intend to limit the scope of EMTALA to

to the hospital seeking emergency care, not just those who are Medicare beneficiaries.¹¹ The law requires hospitals to do three basic things.

First, the hospital must provide an appropriate medical screening examination to determine if the patient really has a medical emergency (or is a pregnant woman in labor).¹² Second, if an emergency condition exists, the hospital must provide, within its capability, whatever treatment is necessary to stabilize the emergency condition.¹³ And third, the hospital may not transfer a patient in unstabilized emergency condition to another facility unless the patient requests the transfer, or a physician certifies that the benefits of the transfer outweigh the risks.¹⁴

B. Enforcement Mechanisms

Congress created two different enforcement mechanisms for this law — government enforcement by the Department of Health and Human Services (DHHS), and the right to file private lawsuits.¹⁵ Government enforcement is split between two components within DHHS: The Health Care Financing Administration may terminate the agreement that allows a hospital to receive Medicare and Medicaid funds,¹⁶ and the Office of Inspector General may fine hospitals or individual doctors up to \$50,000 for each violation, and may exclude physicians from Medicare and Medicaid for gross and flagrant, or repeated, violations.¹⁷

only hospitals with specifically designated emergency departments. "If so, a facility could easily circumvent its responsibilities . . . simply by renaming the department . . . or by using an approach other than departmentalization in providing hospital services. This would clearly contravene the underlying principle of the statute." 59 Fed. Reg. 32,086, 32,101 (1994).

11. See 42 U.S.C.A. § 1395dd(a) (West 1997) (stating that the services participating hospitals must provide to individuals seeking emergency care and to women in labor are not restricted to individuals receiving benefits under this subchapter).

12. See *id.*

13. See *id.* § 1395dd(b).

14. See *id.* § 1395dd(c).

15. See *id.* § 1395dd(d).

16. See *id.* § 1395cc(b)(2).

17. See *id.* § 1395dd(d)(1). The amount of the civil money penalty applicable to hospitals and physicians was increased from \$25,000 to \$50,000 in 1987. See Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, § 4009(a)(1), 101 Stat. 1330, 1356 (1997). However, a 1990 amendment limits the penalty to \$25,000 in the case of a hospital with fewer

These are serious penalties because most hospitals, and many physicians, depend on Medicare for a large part of their revenue. However, in practice, a hospital with a confirmed EMTALA violation will only be dropped from Medicare if it fails to take corrective action within a designated time¹⁸ sufficient to satisfy HCFA that no further violations will occur. This policy reflects HCFA's priority on obtaining compliance with the law without reducing the number of hospitals available to serve Medicare beneficiaries. In cases where penalties might be warranted despite corrective action by the hospital, HCFA looks to the Office of Inspector General to impose monetary fines.

From 1993 to 1995 (the most recent data available), both the number of "dumping" complaints received by HCFA and the number of confirmed violations increased significantly. In 1995, HCFA received 460 complaints compared to 308 in 1994 and 338 in 1993. The percentage of complaints leading to confirmed violations of the law increased from twenty-one percent in 1993 to thirty-three percent in 1994 and thirty-eight percent in 1995.¹⁹ EMTALA activity has also increased in the Inspector General's office, which, since 1986, has settled about seventy cases involving civil money penalties totaling close to \$1.5 million. Approximately half of those seventy cases were settled in the last two years alone.²⁰

Perhaps recognizing that the government agency would always have limited resources, Congress also created a private

than 100 beds. See Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, § 4008(b)(2), 104 Stat. 1388 (1990). A third division of DHHS, the Office of Civil Rights, may also investigate alleged EMTALA violations that might violate the "community service assurance" provisions of the Hill-Burton Act of 1944. 42 U.S.C.A. § 291c(e) (West 1997) (prohibiting hospitals that have received Hill-Burton funds for construction and modernization from denying services to any person who works or resides in the hospital's service area, and requiring "a reasonable volume of services to persons unable to pay therefor").

18. A hospital that has been found to have violated EMTALA may be terminated from the Medicare and Medicaid programs if it does not submit a plan of correction that is acceptable to HCFA within 23 days of the date the violation was confirmed. See HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, MEDICARE/MEDICAID STATE OPERATIONS MANUAL, Part 3412 (Rev. 1/95).

19. Enforcement Statistics, Health Care Financing Administration (on file with the authors).

20. *Id.* In addition to the settlements negotiated by the Inspector General since 1986, 117 cases were closed without further action, 130 are currently in active negotiation, and 50 cases are under review by a Medicare Peer Review Organization (PRO).

right of action, whereby a patient who has been harmed by a violation of EMTALA may personally sue the hospital for damages.²¹ While some critics of the law have complained that this has usurped state authority by creating a federal form of medical malpractice law, courts have consistently rejected that notion over the last ten years.²² However, EMTALA claims have become a popular “cause of action” to tack on to state medical malpractice claims whenever the incident involved a hospital emergency room.

III. THE EMTALA REGULATIONS

A. Rulemaking History

While EMTALA lays out these basic requirements and procedures, statutes are notoriously ambiguous — the result of political compromises that muddy what the original sponsors had in mind. We therefore look to government regulations and guidelines to clarify and operationalize federal laws. The rulemaking process for EMTALA was complicated by several amendments²³ to the law after publication of a proposed rule in 1988.²⁴ On the other hand, HCFA reaped the benefit of numerous court decisions, which clarified some important aspects of the law’s interpretation and Congressional intent.

For example, *Burditt v. U.S. Department of Health and Human Services*²⁵ confirmed that EMTALA’s protection is not

21. See 42 U.S.C.A. § 1395dd(d)(2) (West 1997) (describing the civil remedies available to a person who has suffered physical harm as a direct result of a participating hospital’s violation of this section). This provision also allows a medical facility that suffers a financial loss as a direct result of an EMTALA violation to sue the responsible hospital for damages. *Id.*

22. See, e.g., *Vickers v. Nash General Hosp., Inc.*, 78 F.3d 139, 142 (4th Cir. 1996) (stating that EMTALA was not intended as a federal malpractice statute; citing the same conclusion by the 1st, 8th, 9th, 10th, 11th, and D.C. Circuits).

23. See generally Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §§ 6003(g)(3), 6018, 6211, 103 Stat. 2106, 42 U.S.C.A. §§ 1395ww, 1395cc, 1395dd (West 1997); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4008, 4207, 104 Stat. 1388, 42 U.S.C.A. 1395y (West 1997) (amending provisions of EMTALA).

24. 53 Fed.Reg. 22,513 (1988) (proposed rules).

25. 934 F.2d 1362, 1373 (5th Cir. 1991) (refusing to find that EMTALA covers only indigent and uninsured individuals). See also *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991) (stating that the Act “does not set forth any specific economic status criteria that limit the types of individuals covered by the Act”); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991) (stating that “the Act itself draws no distinction between persons with and without insurance”).

limited to people denied emergency care because they are poor or uninsured, but applies to *all* persons who are denied appropriate screening or stabilizing treatment, regardless of the hospital's motive for withholding such care. *Johnson v. University of Chicago Hospitals*²⁶ addressed the circumstances in which the law applies when a hospital diverts an ambulance en route so that the patient never physically arrives at the hospital.

HCFA incorporated these rulings into the interim final EMTALA regulation, published in 1994,²⁷ and tried to address other common sources of confusion — for example, whether the law applies to psychiatric emergencies. (It does.)²⁸

B. Highlights of the Interim Final Rule

The interim final regulation for EMTALA tracks the basic requirements of the law: that hospitals must provide appropriate screening examinations and stabilizing treatment for medical emergencies and may not transfer an unstabilized patient to another facility unless the benefits of the transfer outweigh the risks.²⁹ The rule also explains the secondary requirements of

26. 982 F.2d 230, 233 (7th Cir. 1992) (stating that mere contact between an ambulance and a telemetry system operated by a hospital is not sufficient to trigger the hospital's obligations under EMTALA). In its interim final regulation, HCFA states that a patient who is in an ambulance on the hospital's premises, or is off the premises in an ambulance owned and operated by the hospital, is considered to have "come to the hospital's emergency department" for EMTALA purposes. 59 Fed. Reg. 32,086, 32,121 (1994). This approach prevents hospitals from defeating the intent of the law by simply diverting ambulances away from the hospital door, while following the principle enunciated in *Johnson* that telemetry contact with a hospital is not by itself sufficient to trigger EMTALA without some further connection with the hospital. See *id.* at 32,098.

27. Interim final rule with comment period, 59 Fed. Reg. 32,086 (1994) (*codified at* 42 C.F.R., part 488 (1997)). The rule is considered "interim" only for provisions that were added since the proposed rule was published in 1988, to conform with statutory amendments passed in 1989 and 1990. Public comment was invited for these new provisions when the interim final rule was published, and any comments received will be considered in development of a future final rule.

28. The preamble to the interim final regulation notes that, while many psychiatric hospitals do not have organized emergency departments, many do present themselves to the public as providing care for psychiatric emergencies on a 24-hour walk-in basis. Thus EMTALA requirements would apply to these hospitals (if they participate in Medicare). EMTALA also applies to both psychiatric emergencies for which treatment is sought in a general hospital, and to treatment sought for acute symptoms of substance abuse. These conditions are specifically cited in the definition of "[e]mergency medical condition," included in the regulation. *Id.* at 32,121 (*codified at* 42 C.F.R. 489.24(b) (1994)).

29. 59 Fed. Reg. 32,086, 32,092, 32,120, 32,122 (1994) (*codified at* 42 C.F.R. § 489.24 (implementing Social Security Act § 1867(a)-(c))).

the law, many of which were added by amendments to the statute in 1989 and 1990.³⁰ For example, a hospital must maintain a list of on-call physicians available to treat emergency patients, and must post conspicuous signs alerting patients of their right to emergency care, and whether the hospital participates in Medicaid.³¹ A hospital may not delay screening or treatment to inquire about the patient's payment method or insurance status.³² And a hospital with specialized capabilities (such as a burn, trauma, or neonatal intensive care unit) may not refuse to accept an appropriate transfer of a patient who needs such specialized care, within the hospital's capability to provide it.³³

The regulation also specifies that hospitals that receive an unstable patient whom they have reason to believe was transferred from another facility in violation of EMTALA must report the potential violation to HCFA or the state health agency. Hospitals that fail to report possible violations are themselves subject to termination from Medicare.³⁴

30. See generally Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 §§ 6003(g)(3), 6018, 6211, 103 Stat. 2106, 42 U.S.C.A. §§ 1395ww, 1395ee, 1395dd (West 1997); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4008, 4207, 104 Stat. 1388, 42 U.S.C.A. 1395y (West 1997) (amending EMTALA).

31. See 59 Fed. Reg. 32,086, 32,089, 32,120 (1994) (codified at 42 C.F.R. § 489.20(g)(2)) (1994) (implementing Social Security Act §§ 1866(a)(1)(I)(iii), (N)(iii), (N)(iv), 42 U.S.C.A. 1395(cc)) (West 1997).

32. See 59 Fed. Reg. 32,086, 32,090, 32,121 (1994) (codified at 42 C.F.R. § 489.24(c)(3)) (1994) (implementing Social Security Act § 1867(h), 42 U.S.C.A. 1395(dd)(1997)).

33. See 59 Fed. Reg. 32,086, 32,090, 32,122 (1994) (codified at 42 C.F.R. § 489.24(e)) (1994) (implementing Social Security Act § 1867(g), 42 U.S.C.A. 1395(dd)(g)).

34. See 59 Fed. Reg. 32,086, 32,094, 32,120 (1994) (codified at 42 C.F.R. § 489.20(m)) (1994) (discussing the responsibility of Medicare-participating hospitals to report to HCFA when they suspect that a patient has been transferred to a facility from another facility in violation of EMTALA). Some comments to HCFA's proposed EMTALA regulation in 1988 questioned the agency's authority to require recipient hospitals to report suspected violations, which is not stated explicitly in the law. The statutory basis for the requirement is found in two provisions of the Social Security Act: § 1861(e)(9) (authorizing the Secretary of Health and Human Services to impose rules necessary to ensure the health and safety of persons receiving hospital services), and § 1866(b)(2)(A) and (B) (authorizing the Secretary to terminate a Medicare provider agreement for failure to comply with any program requirement). In the preamble to the interim final regulation, HCFA notes that receiving hospitals are "in the best position to discern when an inappropriate transfer has taken place in violation of the statute, because Congress regards them also as victims of 'dumping.'" 59 Fed. Reg. 32107 (1994). See also Social Security Act § 1867(d)(2)(B) (allowing hospitals to sue for financial loss suffered as a result of an EMTALA violation). While the exact impact of the reporting requirement has not been documented, about half of HCFA's regional offices report that complaints from recipient hospitals about inappropriate transfers to their emergency departments have increased since the reporting requirement took effect in September 1995. However, no penalties have been imposed, to date, for

Finally, the regulation spells out the procedure to be used for referral of cases from HCFA to the Inspector General's office. When an alleged violation involves a question of medical judgment, HCFA must seek review by the state's Medicare Peer Review Organization (PRO) before referring the case to the Inspector General for consideration of civil fines.³⁵ HCFA also usually seeks PRO review on "medical judgment" cases prior to deciding whether a violation occurred, though this is not currently mandated by the regulation or the law.

IV. THE EMTALA WORK GROUP

A. Creation and Goal of the Work Group

As with statutes, the publication of final regulations is not the last word. Some points, thought to be crystal clear when the regulation was written, prove ambiguous over time and issues not initially envisioned by the agency arise. Those regulated by the regulation may also view some rules as unfair, wrongly applied, or applied inconsistently in different parts of the country.

In April 1996, the American Hospital Association (AHA) requested a meeting with HCFA to discuss its members' concerns about HCFA's enforcement of EMTALA. At that meeting, HCFA and the AHA agreed to convene a work group composed of representatives of professional organizations and their constituents to examine issues related to EMTALA and its implementation.

The group first met in June 1996, again in September 1996, and for the last time in January 1997. It included representatives of hospital groups, physician groups, managed care associations, state health departments, HCFA's regional offices, and consumer groups.³⁶ The work group's goal was to pro-

a recipient hospital's failure to report a suspected violation.

35. See 59 Fed. Reg. 32,089, 32,122-23 (1994) (*codified at* 42 C.F.R. § 489.24(g) (1994)) (implementing Social Security Act § 1867(d)(3)). PROs are federally funded state-level agencies contracted by HCFA to monitor the utilization and quality of Medicare services in each state. See *generally id.* § 489.24(g)(1).

36. Organizations represented on the work group included the American Hospital Association, the American Medical Association, the American College of Emergency Physicians, the American Association of Health Plans, the Health Care Financing Administration, the Medicare

duce consensus recommendations for clarifications or changes to the statute, regulation, or HCFA's interpretive guidelines (enforcement procedures), with emphasis on changes that could be implemented quickly without legislative action or a formal rulemaking process. To achieve this goal, the work group divided into three subgroups addressing the following issues: (1) definitions and interpretations of key terms in the law, (2) the enforcement process and procedures, and (3) points of interface between EMTALA and managed care.

In January 1997, the overall work group submitted recommendations to HCFA on which each of the three subgroups had reached consensus — that is, the subset of items considered by the subgroups on which the hospitals, physicians, managed care plans, consumer groups, state health departments, and HCFA representatives were able to agree.

B. Consensus Recommendations Submitted by the Work Group to HCFA

Each subgroup considered a range of aspects of EMTALA that they considered to be unclear, unfair, or inconsistently or inappropriately enforced. Several examples of topics addressed by the work group are described below.

1. Definitions Subgroup

The Definitions Subgroup considered how to further clarify the interpretation of the following key terms in the law:³⁷

a. "Appropriate medical screening examination"

What constitutes an "appropriate medical screening examination?" The subgroup proposed defining this term as the process required to determine, with reasonable clinical confidence, whether an emergency condition exists, and for such screening to be applied in a nondiscriminatory manner.³⁸ They noted

Peer Review Organizations, the Association of Health Facility Survey Agencies, the American Association of Retired Persons, and Public Citizen's Health Research Group.

37. See Recommendations from the Definitional Issues Group of the Section 1867 Task Force, Draft Nov. 27, 1996, at 2-3 (providing definitional interpretations of "appropriate medical screening examination" and "to stabilize") (on file with the authors).

38. This clarification proposed by the Definitions Subgroup is consistent with the definition

that a screening examination may range from simple to complex depending on the patient's symptoms; that it is not the same as triage (which merely determines the *order* in which patients will be seen, not the presence or absence of an emergency condition); and that the clinical outcome of a patient's condition should not be the basis for determining whether a screening examination was adequate.³⁹

b. "Stabilized"

When should an emergency condition be considered "stabilized?" The subgroup proposed different criteria for patients "stabilized" and then transferred to another facility for further care, as opposed to patients "stabilized" and then discharged to home. For patients transferred to another facility, they would

of "medical screening examination" included in the statute at Social Security Act § 1867(a), 42 U.S.C. § 1399dd(a). EMTALA case law decisions have also based the determination of whether a screening examination was adequate on comparisons to services provided to other patients (for example insured patients) who presented to the hospital with the same symptoms or complaint. *See, e.g.*, *Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, 710-711 (4th Cir. 1993) (stating that "the hospital must supply its standard of screening *uniformly* to all emergency room patients regardless of whether they are insured or can pay"); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (finding no indication that the outcome would have been different for a patient of different sex, race, national origin, financial condition, etc.).

39. The role of clinical outcomes in EMTALA cases has long been a concern to physicians and hospitals, some of whom have argued that EMTALA imposes a strict liability standard, which is inappropriate in the inexact realm of emergency medical care. However, the statute itself suggests that an objective test is to be used in assessing the adequacy of the care provided to patients under EMTALA. While not explicitly addressed in the definition of a medical screening examination, the law defines the term "to stabilize" as the provision of "such medical treatment of the condition as may be necessary to assure, *within reasonable medical probability*, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility." Social Security Act § 1867(e)(3)(A), 42 U.S.C. § 1395dd(e)(3)(A) (West 1997) (emphasis added). This language is based on the common negligence standard, which would consider whether a reasonable physician, under the same or similar circumstances, would have believed that the steps taken to assess and treat the patient's medical condition were adequate to confirm or rule out the existence of an emergency, and to stabilize any emergency condition found to exist. Courts have consistently ruled that a medical screening exam may be deemed adequate without necessarily producing an accurate diagnosis. *See, e.g.*, *Baber v. Hospital Corp.*, 977 F.2d 872, 879 (4th Cir. 1992) (stating that EMTALA "does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of this screening"); *Brooks*, 996 F.2d, at 711 (stating that "[t]he Act does not impose any duty on a hospital requiring that the screening result in a correct diagnosis."). Thus, an adverse clinical outcome does not necessarily lead to a finding of a violation. Conversely — for the purpose of government enforcement — the absence of patient harm does not necessarily prove that no violation occurred. However, the private right of action authorized by the law, *see supra* note 21, is limited to cases where a patient can demonstrate actual harm as a result of an EMTALA violation. Social Security Act § 1867(d)(2)(A), 42 U.S.C. § 1395dd(d)(2)(A).

consider the patient stabilized if the treating physician reasonably believed that the patient was likely to arrive at the second facility with no material deterioration in his or her condition, and reasonably believed that the second facility was capable of managing any follow-up complications to the patient's condition. For patients discharged to home, they would consider the patient stabilized if the treating physician reasonably believed that the patient could have received necessary follow-up care on an out-patient basis or a later scheduled in-patient basis, provided that the patient had been given appropriate discharge instructions and a reasonable plan for follow-up care.

In the case of psychiatric emergencies, the subgroup would consider patients who are transferred from one facility to another facility to be "stabilized" when they have been prevented from injuring themselves or others (such as being chemically or physically restrained). Psychiatric patients discharged to home would be deemed stabilized when they are no longer considered a threat to themselves or others.

c. EMTALA and EMS protocols

What is the relationship between EMTALA and emergency medical services (EMS) protocols?⁴⁰ The subgroup proposed circumstances under which a hospital that complies with an EMS protocol should be deemed to have met its obligations under EMTALA. For example, if a helicopter ambulance lands on the rooftop helipad of one hospital and the patient is immediately transported by ground ambulance to another hospital pursuant to a community-wide protocol, the patient should not be considered to have "come to the hospital" for the purpose of triggering the first hospital's EMTALA obligations.

40. Emergency medical services (EMS) systems provide guidelines for pre-hospital treatment and transport of patients with emergency medical conditions within a given geographic area. Such services are generally coordinated by a centralized authority, which can direct ambulances and emergency service personnel to the most appropriate facility to treat a particular illness or injury.

2. Enforcement Procedures Subgroup

The Enforcement Procedures Subgroup urged HCFA to consider the following changes in its enforcement processes and procedures:⁴¹

a. "Medical care" violations v. "administrative" violations

The subgroup recommended that HCFA distinguish "medical care" violations from "administrative" violations, with different enforcement procedures applied to each type. Alleged medical care violations (for example, complaints about the adequacy of a screening examination or stabilizing treatment) would always be reviewed by the State's Medicare Peer Review Organization (PRO) before HCFA made a compliance determination. In such cases, a 23-day "fast track" termination process would be allowed only if the hospital's current practices would place patients at risk. Otherwise, the hospital would have 90 days to submit a plan of correction⁴² and demonstrate compliance before it could be terminated from Medicare. In contrast, alleged administrative violations (for example, failure to post conspicuous signs about patients' rights under EMTALA, or to maintain proper transfer records) would not need PRO review (unless specifically requested by the hospital), and would always follow a 90-day corrective action timeframe.⁴³

41. See Memorandum from the Subgroup on Enforcement Process and Procedures to the Primary Group of Section 1867 Provisions, Dec. 13, 1996 (listing recommendations to be considered by HCFA) (on file with the authors).

42. A "plan of correction" is a written plan submitted by a health care facility on HCFA Form 2567 (*Statement of Deficiencies and Plan of Correction*), describing corrective actions the hospital will take to remedy cited deficiencies, and the completion date for such correction.

43. Under current policy, a 23-day "fast track" termination timetable is considered appropriate for all cases where an EMTALA violation has been found. See HEALTH CARE FIN. ADMIN., *supra* note 18, at Part 3010. In contrast, a hospital found in violation of one or more of Medicare's 20 "conditions of participation" (for example, standards for infection control or nursing services) will only be placed on a 23-day termination schedule when the violation is determined to pose an "immediate and serious threat" to patients' safety or health. In other cases, the hospital is given 90 days to submit evidence that the cited deficiencies have been corrected or that the violation did not, in fact, occur. HEALTH CARE FIN. ADMIN., *supra* note 18, at Part 3012. The workgroup proposed that the same 23-day and 90-day options be applied to EMTALA violations as are used for other hospital deficiencies, and that the choice should be based on a "medical care" versus "administrative" distinction. See Memorandum from the Subgroup on Enforcement Process and Procedures, *supra* note 41.

b. No admission of liability

The subgroup recommended that HCFA specify in regulations that a plan of correction submitted by a hospital does not imply that the hospital admits that a violation occurred. This would be analogous to a standard clause included in EMTALA settlement agreements negotiated by the Inspector General's office, which states that the hospital or doctor does not admit to having violated the law but that they agree to pay a specified sum of money in order to avoid litigation of the case.⁴⁴ Similar clauses are common in all types of legal settlements, which are intended to dispose of potential litigation without a trial or formal finding by a jury or court.

c. Simplify procedures and monitor survey agencies

The subgroup recommended that HCFA more closely monitor state survey agencies' application of the EMTALA rules⁴⁵ and simplify its investigation and enforcement procedures. For example, the subgroup urged HCFA to consolidate all EMTALA rules and guidelines in a single manual for the regional offices and state agencies, which should also be shared with the hospitals.

3. Interface With Managed Care

The third subgroup, addressing EMTALA's interface with managed care, submitted a statement of principles, including the following points:⁴⁶

a. Prior authorization

It is not appropriate for a hospital to request, or a managed care plan to require, prior authorization before a medical

44. EMTALA settlement agreements on file with the Office of Inspector General, U.S. Department of Health and Human Services.

45. See 42 U.S.C.A. § 1395aa (West 1997) (authorizing the Secretary of Health and Human Services to contract with state agencies to determine compliance of Medicare-participating facilities with conditions of participation in Medicare [including compliance with § 1867]).

46. See INTERFACE WITH MANAGED CARE WORKGROUP, CONSENSUS PAPER ON MANAGED CARE/EMERGENCY DEPARTMENT ISSUES RELATING TO COBRA/EMTALA, Draft revised Nov. 14, 1996 (on file with the authors).

screening exam or before an emergency condition is stabilized. However, once the patient is stabilized, EMTALA no longer applies and the plan *may* require prior authorization for further services.

b. Define the emergency according to patient's perspective

Managed care plans should pay for screening examinations whenever a patient's symptoms *could* indicate a medical emergency, even if the exam subsequently rules out the existence of a genuine emergency. This principle represents a tentative approach to the "prudent layperson" standard, a version of which was recently passed in federal budget legislation and is proposed in other bills still pending in Congress (discussed further below).

c. Determination based on treating physician's judgment

If a disagreement occurs between a hospital emergency department and a managed care plan as to whether a plan member has an emergency condition, or whether that condition has been stabilized, the decision should be made by the examining physician at the hospital, both for the purpose of the hospital's compliance with EMTALA, and for the purpose of the plan's payment for the services.

d. Training for managed care plans

While there seems to be a high level of awareness of EMTALA among hospitals and emergency room staff, managed care plans are much less familiar with the law and the obligations it places on hospitals. Thus, the subgroup urged widespread education about EMTALA for managed care providers.

C. Comments on the Work Group's Recommendations

In evaluating the work group's recommendations, it is important to note that some of its proposals are, in fact, *already* in HCFA's regulation and policies. The fact that they show up in these recommendations suggests that either those

policies are still not understood by all providers or there exists a perception that they are not enforced properly or consistently.

On the other hand, some recommendations do suggest *changes* from current policy, which HCFA has promised to consider very carefully. However, some proposed changes may conflict with the agency's interpretation of what the statute requires. HCFA's internal review of the work group's proposals will include a careful legal assessment to identify any possible conflicts with statutory mandates.

Similarly, the recommendations related to managed care primarily focus on issues that HCFA lacks statutory authority to enforce — at least for managed care plans that are not Medicare contractors. Thus, these proposals should be viewed — and were apparently intended — as statements of principle directed at providers, as well as recommendations for change in Medicare policies.

Finally, apart from the substantive changes that will come from the work group's recommendations, the group has also had another very positive effect — as a model of cooperation between parties with quite differing agendas coming together, at an early stage, to consider how a government policy should be created or changed. It is not the first time a process like this has been used, but the HCFA participants viewed this group as a particularly successful example of productive, collaborative policymaking. The process also recognizes that groups affected by a policy on a day-to-day basis are the real experts, and that some policies *should* be changed, some should be better explained, and some could be applied more consistently.

D. Next Steps Toward Implementing the Work Group's Recommendations

In January 1997, the work group submitted its recommendations to HCFA, which incorporated them into a draft revision of the agency's interpretive guidelines for EMTALA. These guidelines are used to explain the law and regulation to those who carry out the agency's survey and enforcement activities — primarily HCFA's ten regional offices and state survey agencies. The draft guidelines were then circulated to outside groups for comment, including review by the larger member-

ships of each of the organizations represented on the work group. Their comments were used to further refine the draft guidelines, which were submitted for formal approval within HCFA in September 1997. After a final version is approved, training based on the new guidelines will be conducted for HCFA's regional office staff and state agency surveyors during fiscal year 1998. This series of steps was originally expected to be completed by the end of September 1997, but the process was slowed down by a major reorganization of HCFA, which took effect on July 1, 1997.

Despite this delay, HCFA has expressed its commitment to adopt policy and procedural changes that follow the work group's suggestions as closely as possible. However, the draft guidelines are not yet approved by the agency. In the end, some may be excluded, and others may look somewhat different once final revisions are made. Issues not addressed in the guidelines, which may require a regulatory change, will be considered in the future development of a final EMTALA regulation.⁴⁷ The work group also expressed interest in revisiting some issues on which consensus was not reached in its initial round of meetings.

V. NEW CHALLENGES

While the revised surveyor guidelines will bring a new level of consistency to the government's enforcement of EMTALA, the current health care landscape poses daunting challenges to those who seek to ensure access to emergency medical care as intended by this landmark law. As a starting point, it is important to acknowledge without apology that EMTALA is about *access*, not payment. It envisioned that hospitals *would* have to absorb some uncompensated care, but by preventing inappropriate transfers, largely to public hospitals,⁴⁸ Congress intended to spread the burden to all providers

47. HCFA will still publish a final regulation for EMTALA to respond to comments received on aspects of the 1994 Interim Final Rule implementing amendments to the law that were enacted in 1989 and 1990, after publication of the Notice of Proposed Rulemaking in 1988. See 59 Fed. Reg. 32,086 (1994) (*codified at* 42 C.F.R. § 488 (1994)).

48. Prior to the enactment of EMTALA, several researchers attempted to calculate the dollar impact of emergency transfers from private hospitals to public hospitals. A study published

in a community. However, in 1997 all roads lead to managed care, which presents new twists not envisioned by Congress in 1986.

A. Challenges Posed by Managed Care

While concerns about access to emergency services once focused only on hospitals, today the spotlight is more frequently turned on managed care.⁴⁹ Hospitals and physicians seeking to comply with EMTALA have expressed frustration with the refusal of some plans to pay for emergency care provided to their members in a non-network hospital.⁵⁰ Unlike the classic victims of "dumping," these patients are *not* uninsured, but are paying premiums to managed care plans for all necessary medical services, including emergency care.

The essential problem is that emergency care is an exception to the rule that a managed care plan may limit its

in 1986 in the *New England Journal of Medicine* estimated that, in 1983, emergency transfers from other hospitals to Chicago's Cook County Hospital (the only public general hospital in that city) cost the county \$24.1 million in uncompensated care, or 12% of the hospital's total operating budget that year. Extrapolating this result nationally, the authors estimated "an annual cost shift of hundreds of millions of dollars from the private to the public sector." Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 *NEW ENG. J. MED.* 552, 556 (1986). See also David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 *AM. J. OF PUB. HEALTH* 494, 495 (1984) (suggesting that "[d]umping" unprofitable patients and services may be responsible for at least part of the deficits which have plagued public hospitals and represents a *de facto* public subsidy to private hospitals"). In their periodic reports on HCFA's enforcement of EMTALA, Public Citizen's Health Research Group has noted that for-profit hospitals are significantly more likely than non-profits to violate the law. In 1993 through the first quarter of 1995, between 27 and 29% of the hospitals cited by HCFA for EMTALA violations were for-profit hospitals while only 14 to 19% of all general hospitals in the United States were for-profit during this period. See JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UPDATE ON "PATIENT DUMPING" VIOLATIONS (Oct. 1994) (citing statistics for patient dumping violations); LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UPDATE: PATIENT DUMPING IN HOSPITAL EMERGENCY ROOMS (Mar. 1996) (giving statistics regarding hospitals and doctors cited for patient dumping).

49. The term "managed care" encompasses a range of health care delivery and financing arrangements which seek to control costs through a variety of mechanisms. Common strategies include use of primary care "gatekeepers," prior authorization for specialty care, and stringent utilization review procedures. Many insurers that pay for health care on a traditional fee-for-service basis have also adopted some managed care techniques, often by paying a substantially greater portion of the bill for services furnished by a "preferred provider." As used in this Article, the term "managed care" refers to any arrangement that in some way limits a patient's choice of provider.

50. See, e.g., *Standards For Health Plans Providing Coverage In The Medicare Program: Hearing Before The Subcomm. On Health Of The Comm. On Ways And Means and The Subcomm. On Health And Environment Of The Comm. On Commerce*, H.R. 104th Cong. 150 (1995) (statement of Richard V. Aghobabian, M.D., American College of Emergency Physicians).

members' choice of doctor or hospital to those providers who have negotiated contracts with the plan. But in the case of medical emergencies, plans generally agree that the patient may go to the nearest hospital, whether or not it is a participant in the plan. Medicare-participating managed care plans *must* cover emergency care by non-plan providers without requiring prior authorization from the plan.⁵¹

This broad obligation to pay for emergency services has led to new scrutiny of what qualifies as an "emergency." In cases where a non-plan hospital provides a medical screening examination — as mandated by EMTALA — and determines that the patient's chest pain was indigestion, not a heart attack, the plan may say: "Sorry, not a true emergency. We won't pay."⁵²

B. Legislative Proposals About Emergency Medical Care

1. Establishing a "prudent layperson" standard

A popular response to this dilemma is the so-called "prudent layperson" standard, versions of which are included in legislation passed (or being considered) by a number of states,⁵³ in the balanced budget bill signed by President Clinton on August 5, 1997 (as applied to Medicare and Medicaid managed care plans),⁵⁴ and in several bills still pending in

51. See 42 U.S.C.A. § 1395mm(c)(4)(B) (West 1997) (requiring Medicare-contracting managed care plans to cover emergency services provided "other than through the organization") (amended by the Balanced Budget Act of 1997, Pub. L. 105-33, § 4001, effective Jan. 1, 1998, which also prohibits prior authorization requirements for emergency services); 42 C.F.R. § 417.401 (1997) (defining "emergency services" to include services provided by "other than the HMO or CMP"); 42 C.F.R. 6,414(c)(1) (prohibiting managed care contractors from requiring prior authorization for emergency services).

52. See, e.g., *Emergency Doctors Faced with Catch-22 as HMOs Impede Access to Emergency Care*, Health Letter (Pub. Citizen Health Res. Group, Wash., D.C.), Feb. 1995, at 1 (offering scenarios where necessary emergency services are not covered by HMOs); Robert Pear, *HMO's Refusing Emergency Claims, Hospitals Assert*, N.Y. TIMES, July 9, 1995, at A1 (illustrating the frustration physicians experience when they think a patient is in need of emergency care and the HMO refuses to pay, claiming it is not an emergency).

53. See Diane E. Hoffman, *Emergency Care and Managed Care — A Dangerous Combination*, 72 WASH. L. REV. 315, 368-69 (1997) (describing and analyzing how current restrictive plan practices related to emergency medical treatment harm both patients and providers and arguing for legislative action); Anthony So, *Access to Emergency Services* (June 19, 1997) (preliminary draft of unpublished manuscript prepared for the Subcommittee on Consumer Rights, Protections, and Responsibilities of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry) (on file with the authors).

54. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 290 (to

Congress (which would apply to *all* payers, not just Medicare and Medicaid).⁵⁵ The common element of all these proposals is that they would define a medical emergency from the perspective of a reasonable layperson experiencing symptoms (e.g. chest pains) rather than the perspective of a physician or insurer after-the-fact. Specifically, "emergency medical condition" is defined in most of the proposals as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.⁵⁶

This definition closely parallels that included in EMTALA,⁵⁷ and is clearly intended to bridge the gap between those services that hospitals are mandated to provide under EMTALA and those services for which managed care plans are obligated to pay. The new balanced budget law and the pending bills would also require plans to cover emergency services "without regard to prior authorization or the emergency care provider's contractual relationship with the [plan]."⁵⁸

be codified at 42 U.S.C.A. 1395W-21) (defining "emergency services" according to a "prudent layperson" standard for Medicaid managed care plans); Balanced Budget Act of 1997, Pub L. No. 105-33, § 4704, 111 Stat. 251, 496 (to be codified at 42 U.S.C.A. § 1396v) (defining emergency services according to a "prudent layperson standard" for Medicaid managed care plans).

55. See Access to Emergency Medical Services Act of 1997, S. 356, 105th Cong. § 9811(a)(2)(A) and H.R. 815, 105th Cong. § 9811(a)(2)(A); Health Insurance Bill of Rights Act of 1997, S. 373, 105th Cong. § 2771 (1997), and H.R. 820, 105th Cong. § 2771 (1997) (establishing standards for protection of consumers in managed care plans and other health insurance coverage); Patient Access to Responsible Care Act of 1997, S. 644, 105th Cong. § 2771 (1997) and H.R. 1415, 105th Cong. § 2771 (1997) (establishing standards for relationships between group health plans and health insurance issuers with enrollee, health professionals, and providers); Managed Care Consumer Protection Act of 1997, H.R. 337, 105th Cong. (1997) (amending standards for Medicare supplemental policies, modifying the Medicare select program and providing other protections for beneficiaries of health plans generally); Quality Health Care and Consumer Protection Act, H.R. 1222, 105th Cong. § 5(B)(2) (1997).

56. See, e.g., S. 356 § 9811(a)(2)(A) and H.R. 815 § 9811(a)(2)(A) (defining "emergency medical condition").

57. See 42 U.S.C.A. § 1395dd(e)(1) (West 1997) (defining "emergency medical condition").

58. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 290.

However, the legislative proposals have also differed on some points, the most hotly contested of which has been whether the definition of an emergency medical condition should include an explicit reference to "severe pain." This phrase was deleted from the "prudent layperson" standard in the preliminary balanced budget bill that was passed by the House of Representatives in late June 1997.⁵⁹ While some observers at first assumed this to be an oversight, it became clear that it was a deliberate omission undertaken in response to intense lobbying by the managed care industry.⁶⁰ The plans objected to the phrase as "a highly subjective term [that] has vast differences in meaning among consumers, depending on their threshold or tolerance for pain."⁶¹ One Health Maintenance Organization (HMO) lobbyist reportedly argued that inclusion of "severe pain" would "require health plans to pay for patients who stubbed their toes and went to emergency rooms for treatment."⁶² Managed care representatives reasoned that the "prudent layperson" standard (without explicit reference to "severe pain") would sufficiently protect consumers who reasonably believe that their health would be in jeopardy without immediate medical care.

On the other side of the issue, the American College of Emergency Physicians (ACEP) argued that omitting "severe pain" from the "prudent layperson" definition "would create a loophole for health plans to deny coverage for . . . beneficiaries who, in severe pain, make a reasonable decision to seek emergency care. This is not only unfair, but dangerous to a patient's health."⁶³ For example, they noted that severe abdominal pain (the leading reason for visits to emergency

59. See H.R. 2015, 105th Cong. § 3463 (1997).

60. See Robert Pear, *H.M.O.'s Fight Plan to Pay For Some Emergency Care*, N.Y. TIMES, June 25, 1997, at A16 (discussing the debate over whether to include "severe pain" as a justification for an emergency room visit covered by managed health care plans).

61. *Id.* (quoting "talking points" prepared by the American Association of Health Plans).

62. *Id.* Similar remarks personally observed by the authors at a meeting of the Subcommittee on Consumer Rights, Protections, and Responsibilities of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, June 25, 1997, Washington, D.C.

63. Letter from the American College of Emergency Physicians and 41 co-signatory organizations to Rep. William M. Thomas, Chairman, Health Subcommittee of the Ways & Means Committee, U.S. House of Representatives (July 11, 1997) (on file with the authors).

rooms) may be a sign of appendicitis, gallbladder infection, ectopic pregnancy, or a ruptured spleen — all of which may be life-threatening if not treated immediately.⁶⁴ ACEP reasoned that “severe pain” would be covered only when the overall “prudent layperson” standard was met. Thus, “health plans would not be required to pay for every patient that reports to an emergency room with severe pain.”⁶⁵

However, the most compelling *legal* argument for retaining the phrase is that it has been included in EMTALA for over a decade. If omitted from the “prudent layperson” definition, ACEP said, “Congress [would] be creating one standard for care and a much lesser standard for coverage that would leave insured consumers paying the bill.”⁶⁶ In the end, the Senate — which had endorsed a definition with the disputed phrase intact — refused to bend on this point in the budget reconciliation process. Thus, the “prudent layperson” standard included in the final budget bill⁶⁷ includes reference to “severe pain,” as it appears in EMTALA and other statutory provisions.⁶⁸

A further point of controversy in the “prudent layperson” proposals involves language included in almost all of the bills that would limit “prudent layperson” protection to those with “an average knowledge of health and medicine.” In contrast, the Clinton Administration’s budget proposal for fiscal year 1998⁶⁹ did *not* include this condition, which HCFA viewed as

64. *See id.*

65. *Id.*

66. *Id.*

67. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 290 (to be codified at 42 U.S.C.A. § 1395w-22) (defining the “prudent person standard”).

68. Provisions of federal law besides EMTALA include the phrase “severe pain” in defining an “emergency medical condition.” *See, e.g.*, 42 U.S.C. § 1395x(v)(1)(K)(i) (West 1997) (authorizing limits on “reasonable costs” for hospital outpatient services other than “bona fide emergency services”). In a review of state laws, the American College of Emergency Physicians identified at least 10 states that include reference to “severe pain” in a statutory definition of “emergency services” or “emergency medical condition.” Those states include Arkansas, California, Florida, Georgia, Louisiana, Maryland, New York, Texas, Virginia, and Washington. *See* Facsimile Transmission from the American College of Emergency Physicians, Language from State Laws that Include “Severe Pain” in the Definition of Emergency Services or Emergency Medical Condition (July 10, 1997) (listing excerpts from a variety of state laws) (on file with the authors).

69. President’s Budget Proposal for Fiscal Year 1998, § 11403. EXCERPT FROM PROPOSED LEGISLATION FOR MEDICARE PORTION OF PRESIDENT CLINTON’S FISCAL YEAR 1998 BUDGET BILL § 11403 (1997) (addressing Medicare-contracting managed care plans’ obligation to cover

providing less protection to beneficiaries than its current policy. It also confuses the common objective legal standard, which considers what a "reasonable person" would do under same or similar circumstances — whether or not those circumstances include an "average knowledge of health and medicine." As an alternative, the Administration bill included the phrase "from his or her perspective," to make clear that the patient's own perspective is paramount. However, this proposal was not adopted by the House or Senate budget committees, and the reconciliation budget bill retained the "average knowledge" language found in other proposed legislation,⁷⁰ as well as in "prudent layperson" laws enacted in several states.⁷¹

Apart from these differences, the degree of consensus in support of a "prudent layperson" standard is remarkable given the controversy it generated when it was first introduced in federal legislation in 1995.⁷² While some disagreements linger

emergency services) (on file with the authors).

70. See, e.g., Access to Emergency Medical Services Act of 1997, S.356, 105th Cong. § 9811 (a)(2)(A) (1997); H.R. 815, 105th Cong. § 9811(a)(2)(A) (1997).

71. See Hoffman, *supra* note 53, at 392 n.356 (citing examples of state statutes using the "prudent layperson" standard); See also Facsimile Transmission from American College of Emergency Physicians, *supra* note 68.

72. See Access to Emergency Medical Services Act of 1995, H.R. 2011, 104th Cong. (1995) (outlining the actions to be taken "to assure equitable coverage and treatment of emergency services under health plans"). In comments on H.R. 2011 submitted by the Health Care Financing Administration to Rep. Benjamin Cardin in September 1995, the agency advised against applying a "prudent layperson" standard to Medicare or Medicaid "because the primary protections afforded by the bill already exist for Medicare and Medicaid beneficiaries." HEALTH CARE FINANCING ADMIN., COMMENTS ON THE APPLICATION OF H.R. 2011 (CARDIN BILL) TO MEDICARE AND MEDICAID, AND TO OTHER PAYORS (1995). However, the agency was eventually convinced that a statutory clarification would strengthen its policy, which was previously described only in manual instructions and operational policy letters to Medicare-contracting managed care plans and State Medicaid Directors. See *id.* (quoting the Health Care Financing Administration's Medicare HMO/CMP Policy Manual § 2104, which directs plans not to "retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature"); HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF MANAGED CARE, OPERATIONAL POLICY LETTER 95-5 (Financial Responsibility for Emergency Services) sent to Medicare-Contracting Health Maintenance Organizations and Competitive Medical Plans (March 27, 1995); Letter from Gale A. Drapala, Deputy Director, Office of Managed Care, Health Care Financing Administration, to state Medicaid director (Oct. 13, 1995) (on file with the authors) (regarding managed care plans and emergency services). Similarly, the American Association of Health Plans (the national trade association for managed care plans) at first opposed the "prudent layperson" proposals because it feared that the standard would undermine efforts to reduce inappropriate use of hospital emergency rooms. However, in 1997, the Association released its "Putting Patients First" initiative, which stated that "[h]ealth plans should cover emergency-room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms." Am. Ass'n. of Health Plans, Press Release, *Health Plans Announce Policies on Appeal Rights and*

over the exact wording to be used, there is now wide acceptance of the need for a “prudent layperson” standard and a ban on requiring prior authorization for emergency care.

2. Requirements for “post-stabilization” care and limits on cost-sharing

Some bills pending in Congress go beyond both the “prudent layperson” standard and the reach of EMTALA to address what happens to a managed care patient in a non-plan hospital whose emergency condition has been stabilized, but who may need further non-emergency care, which the non-plan hospital would like to provide. These bills would set rules for when such care would be deemed to be authorized, with or without prior approval by the plan. For example, the “Access to Emergency Medical Services Act of 1997”⁷³ would require plans to cover “maintenance”⁷⁴ and “post-stabilization”⁷⁵ care identified as necessary through a medical screening exam if the treating physician at a non-plan hospital makes a good faith effort to contact the plan for its authorization within thirty minutes of determining that the patient’s condition has been stabilized.

The bills would also set rules related to cost-sharing⁷⁶ for emergency services. For example, plans would be barred from imposing greater cost-sharing for use of a non-plan emergency provider if circumstances prevented the patient from reaching an in-plan hospital. However, plans would be allowed to im-

Emergency Care Coverage, Jan. 30, 1997.

73. S. 356 §981(b)(3)(A) and H.R. 815 §981(b)(3)(A) (assuring access to emergency medical services under group health plans, health insurance coverage, and Medicare and Medicaid programs).

74. S. 356, 105th Cong. §9811(b)(3)(A) (1997) and H.R. 815, 105th Cong. §9811(b)(3)(A) (1997) (defining “maintenance” care as medically necessary non-emergency services needed to ensure that a patient remains stabilized from the time that the treating hospital attempts to request authorization from the plan until (1) the patient is discharged from the emergency department, (2) a plan physician assumes responsibility for the patient’s care, or (3) the treating physician and the plan agree to another arrangement).

75. S. 356, 105th Cong. §9811(b)(3)(B) (1997) and H.R. 815, 105th Cong. §9811(b)(3)(B) (1997) (defining “post-stabilization” care as medically necessary non-emergency services required by a patient who is determined to be in stable condition).

76. Cost-sharing refers to the portion of the bill for a medical service that the patient is responsible for paying out-of-pocket. In some cases, this is set as a percentage of the total amount (for example, 20% of the payment amount approved for the service by Medicare or a private insurer) or as that fee (for example, \$10 per incident of service).

pose greater cost-sharing for services furnished in an emergency department rather than in another setting, as long as the amount is reasonable.⁷⁷

A simple provision related to “maintenance” and “post-stabilization” care (but not cost-sharing) was also included in the balanced budget bill as applied to Medicare and Medicaid managed care plans. That new law requires plans to cover such care in a non-plan hospital, subject to guidelines that may be established by the Department of Health and Human Services to “promot[e] efficient and timely coordination of appropriate . . . care of [a plan] enrollee after the enrollee has been determined to be stable under section 1867.”⁷⁸

VI. CONCLUSION

Both the recommendations of the work group convened by HCFA last year and Congress’ endorsement of a “prudent layperson” standard for emergency services represent significant steps toward ensuring that the mandate of EMTALA is still alive and enforced in a meaningful way. They also serve as reminders that the problems EMTALA was intended to address do not exist in a vacuum, but are influenced by other policy decisions and developments in the medical marketplace.

While the health care landscape of the ‘90s may have looked unrecognizable in 1986 when EMTALA was passed, the more things change, the more they stay the same. EMTALA was landmark legislation in 1986 and it is still acutely needed today. In that context, HCFA has undertaken a dual commitment: to respond to feedback from hospitals, doctors, patients, managed care plans — the true experts in the field — about how its EMTALA policies and procedures can be improved, while simultaneously maintaining its commitment to carry out the role delegated to it by Congress — to ensure that no person will be denied access to emergency care because of their type of insurance, whether they have insurance at all, or any other non-medical reason.

77. See S. 356, 105th Cong. § 9811(c) (1997) and H.R. 815, 105th Cong. § 9811(c) (1997) (limiting cost-sharing for services furnished in emergency departments).

78. Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4001, 4704, 111 Stat. 251, 290.

