The Law That Changed Everything - And It Isn't the One You Think

By Emily Friedman

Twenty-five years ago, EMTALA was signed into law, transforming health care in ways that are still being felt today

"The immediate goal is to make sure there are more people on private insurance plans. I mean, people have access to health care in America. After all, you just go to an emergency room."

— President George W. Bush, July 7, 2007

It was called a "wallet biopsy." Or "dumping." Very simply, prior to the implementation of the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), a patient coming into a hospital emergency department often had no right to treatment or even evaluation, no matter how dire his or her condition. If patients could not prove that they had the resources to pay for care, they could be turned away or sent elsewhere — sometimes in a taxi, sometimes on foot. They often suffered adverse health consequences as a result of delayed care. And sometimes they died.

Did all hospitals engage in this practice? Of course not. Indeed, as Rick Pollack, executive vice president of the American Hospital Association, puts it, "Because of the mission of so many of our hospitals, they didn't need EMTALA to make them do the right thing in this area. Unfortunately, there were indefensible situations that led to passage of the law."
"Indefensible" is an appropriate term. Ron Anderson, M.D., president and CEO of Parkland Memorial Health and Hospital System in Dallas, was the medical director of the emergency department at Parkland in the early 1980s, and he knew all about dumping. "I would see patients transferred with knives still in their backs, or women giving birth at the door of the hospital, simply because they were uninsured."

As a young reporter in the 1970s and early 1980s, I remember hearing of women in late-stage labor sitting or lying in hospital parking lots, waiting until the baby was ready to be born, when they would then be allowed into the ED. And I heard altogether too many other stories of denial, suffering and death.

Anderson recalls, "I had always said that if I were ever in a position to do something about the situation, I was going to do it." And he did. After he became head of the state board of health, he cajoled, argued and sometimes demanded cooperation from other health care stakeholders in order to get a law passed in Texas that prevented dumping of unstabilized patients because they could not pay for care. One of his fellow advocates showed legislators a photo of a woman who had lost her baby while she was being transferred during active labor. "I was a bit of a bull in a china closet. I broke some china back then, but I had to," says Anderson.

He also began keeping detailed records, and found that between October 1983 and September 1984, of 1,897 patients transferred to Parkland from other sites of care, 537 arrived without Parkland having been informed that they were coming. Parkland also recorded calls from transferring hospitals. In one, a physician said he wanted to transfer a woman with heart failure who was in the ICU. When the Parkland physician asked for more information, the other physician replied, "She does not have any insurance, [and] the hospital does not want to take care of her, OK? This is a private, capitalistic, money-making hospital. They're on my back to have her transferred."

During another call, a physician attempting to transfer a patient told the Parkland physician, "Honey, we're not talking about ethical practice. We're talking about a lady that needs something done that doesn't have the money to do it with… I am dead serious, sweetheart. That's what your damned hospital is there for."
These, and many other shocking incidents, caught the attention of the CBS investigative show *60 Minutes*, which, on March 17, 1985, broadcast an episode titled "The Billfold Biopsy," about the dumping of unstabilized patients at Parkland.

That same year, the Texas legislature finally passed a law requiring all counties to provide for the health care of their indigent residents, and even appropriated some funds to help defray the costs. It was intended to end dumping. Following passage of the Texas statute, more than 20 states passed similar measures, all designed to prevent the transfer of unstabilized patients because of their inability to pay.

Another important milestone, even though it came after the passage of EMTALA, was the 1986 publication of an article in *The New England Journal of Medicine* about transfers of unstabilized patients to Cook County Hospital in Chicago; 24 percent of all transferred patients arrived in unstable condition (Schiff, R.L., and others. "Transfers to a public hospital," NewEnglJMed, Feb. 27, 1986).

**Complex Origins**

It is widely believed that the multiple horror stories about dumping were the primary cause of EMTALA's passage. But according to Larry S. Gage, president of the National Association of Public Hospitals (NAPH) and a partner in the Washington, D.C., law firm of Ropes and Gray, there were two other reasons that have been discussed far less.

Gage says that "EMTALA also grew out of Congressional concerns about the impact of the 1983 Medicare prospective payment system. Hospitals were going to receive a bundled payment for treating patients with a particular DRG, and there was a lot of fear [in Congress] that they would provide fewer services than would be necessary for Medicare patients."

Another observer says that the late Sen. Edward Kennedy (D-Mass.) was the principal proponent of this argument.

Gage goes on to say that a third reason for passage of EMTALA was that some hospitals were no longer obligated to provide indigent care under the Hill-Burton Act. That law, passed in 1946, provided capital funds for reconstruction and improvement of hospitals, with the proviso that they must make care available to low-income uninsured patients, sometimes for 25 years and sometimes in perpetuity. "So by 1986," Gage says, "some hospitals were aging out of Hill-Burton obligations, and it was becoming less effective than it had been in terms of care of uninsured patients." Although Hill-Burton had other requirements for care of Medicare and Medicaid patients, the uninsured were far more vulnerable.
Ironically, he says, "EMTALA was a vehicle that was designed, in large part, to provide protection to Medicare and Medicaid patients. The fact that, in the end, it applied to all patients in all hospitals, even undocumented immigrants, was interesting. And it was good that it did get applied to all patients, especially those whose transfers were economically motivated."

It should be added that the disturbing stories about improper transfers disproportionately involved patients who were members of minority groups, which raised both civil rights concerns and advocacy group ire.

And so, in 1985, a four-page provision called the Emergency Medical Treatment and Active Labor Act was inserted into the Consolidated Omnibus Budget Reconciliation Act, which was duly passed and eventually signed by President Ronald Reagan on April 7, 1986.

**What Does It Mandate?**
There are many misconceptions about what the law requires of hospitals. It does not outlaw transfers of patients who cannot pay or who are otherwise deemed undesirable. It does not (at least as of this writing) require that hospitals provide all care in perpetuity to a patient who receives an evaluation in the ED. It allows for waivers in some situations, such as natural disasters.

What it does require:
- That all patients seeking care in an emergency department be evaluated by a competent clinical professional, and, if found to have a condition requiring emergency care, must be treated until stabilized before any transfer. For women in active labor, the hospital must deliver the baby unless the institution is not equipped to do so (as in the case of a high-risk pregnancy and the lack of a neonatal ICU).

- The hospital to which a stabilized patient (or one who must be transferred because the originating hospital does not have the necessary services or personnel) is to be sent must agree to accept the patient.

- The patient must consent to the transfer, if possible.

- Adequate medical records must accompany the transferred patient.

Of course, there are a million subtleties. For example, what constitutes a medical emergency? What is sufficient stabilization? Who decides whether the transferring hospital has the ability to treat the patient? What if specialist physicians on call refuse the case? What if a patient who appears competent does not consent to the transfer? What if the receiving hospital has no available capacity?
Pollack adds, "How do you connect patients to primary care sites when they present at the ED, and how do you achieve that transition without stumbling into some EMTALA limitations? How do you develop shared community call arrangements for certain specialties or subspecialties — can they be available to multiple hospitals, rather than just one?"

Furthermore, the law has been tweaked many times since it was passed. Indeed, the minutiae of EMTALA may rank second only to those of Medicaid in terms of topics over which policy wonks like to pore.

But one thing is certain: This law comes with a bite. A hospital found to have violated EMTALA is subject to a fine of $50,000 per incident ($25,000 for hospitals with fewer than 100 beds). Offending hospitals also can be terminated from Medicare or Medicaid, although that almost never happens. And unlike some federal health care statutes, EMTALA actually has been enforced, at least sometimes.

And, of course, in the good old American way, if there appears to have been a violation, everyone can sue.

**Violations Still Occur, But…**

At one time or another, at least 1,700 U.S. hospitals have been hit with an EMTALA citation. However, Gage says, "Many are dismissed because the hospital can clarify the situation and the citations don't bear scrutiny." The estimate of serious cases, depending on which data one chooses to examine, is from 50 to 200 per year. However, most of the statistics are woefully out of date.

Pollack points out, "Hospitals have provided 1.5 billion ED visits in the 25 years since EMTALA was passed. A mere fraction have been subject to complaints. And half the complaints were not confirmed violations."

And enforcement has been inconsistent; there have been press reports of what appear to have been flagrant violations, and nothing was done about them. In other cases, even safety-net hospitals have been flagged because of rigid interpretation of the law, and the issue turned out to be nothing more than a paperwork snafu.

But there have been significant recent cases. In 2010, two hospitals, one in Chicago and one in Alabama, agreed to settlements regarding incidents in which patients died. And earlier this year, an Oregon hospital was accused of an EMTALA violation because of its alleged failure to treat a man who was unconscious in the facility's parking garage. This is one of those murky areas involving how much of the hospital campus EMTALA covers. The situation had not been resolved as of this writing, although the hospital insisted that it had not violated the law.
So, although flagrant violations are rare, enforcement continues.

**Still Controversial**

However, EMTALA remains the source of controversy. David C. Seaberg, M.D., president-elect of the American College of Emergency Physicians (ACEP), says that for his membership, "It's a double-edged sword. The good side is that patients with emergency conditions are being taken care of; they must have an evaluation exam and they have to be stabilized. The negative side is that EMTALA is the largest unfunded mandate [on providers] that the government has ever instituted."

The federal government has not been totally insensitive to this burden. The Medicare Modernization Act of 2003 provided $1 billion to hospitals, physicians and ambulance services over four years for emergency care of undocumented immigrants, who are disproportionately represented among ED patients covered by EMTALA. However, that program has ended, and Pollack says that although the AHA is trying to get it reauthorized, the question is, as always, how to pay for it. He adds that the politics are complicated and delicate: "We have citizens who don't have coverage, so why pay for undocumented immigrants? And it's not a real solution to the problem."

In addition to that, Seaberg says, "EMTALA also brings the threat of lawsuits; it added another layer in that patients could now sue under this law. Now, if on the one hand, a hospital is still dumping, then it's appropriate to sue. But if a hospital discharges a patient to a nursing home, and there are complications, and the patient then sues under EMTALA, I wonder about that."

James Hinsdale, M.D., a trauma surgeon and president of the California Medical Association, adds that it can be frustrating for a physician to treat patients who seek care in an ED under EMTALA, but who could pay something for their treatment. "Many of the people who show up at a facility that is obligated to care for them have some ability to pay. They come in the door, and there are some incongruous things accompanying them: a large chromed-out SUV that gets two miles a gallon, iPhones, GPS, other things. Yet we don't ask them for so much as five dollars. But they seem to be able to find money for these other things. I think we need to modify that."

There is also the question of what constitutes a proper transfer. If a patient has been screened and stabilized, but is homeless or undocumented and is reluctant to provide an address, or has substance abuse problems or mental illness, what happens then? Some hospitals in Southern California have been excoriated in the press for discharging patients to shelters (which are not health care facilities) or homeless encampments. "To my knowledge," says Hinsdale, "20 to 25 percent of discharges are to the street. That solves nothing."
A related issue has been the equally controversial practice of hospitals sending undocumented patients with severe chronic conditions back to their home countries, often in air ambulances. Advocates for immigrants have cried foul over this, but the hospitals have argued that there is no place to which these patients can be discharged. This issue, too, remains in flux.

And now there is a new wrinkle, or, rather, an old wrinkle that has popped up again. Pursuant to conflicting court decisions, the Centers for Medicare and Medicaid Services have proposed that EMTALA be extended to cover the patient's entire episode of care, even if that involves months of treatment. The ACEP, the AHA and the NAPH are united in opposition to this proposal.

Maureen Mudron, deputy general counsel of the AHA, explains, "Once an individual has been screened and treated in the ED and admitted in good faith for treatment of an emergency medical condition, the EMTALA requirement has been met. That is consistent with what EMTALA was and is about. This is the third time in 10 years that CMS has raised the issue, and in the past, they have made the right policy decision" — that is, to leave the regulations as they are.

Gage adds, "This is a legal battle that has gone on for 15 or 20 years in the courts. [The NAPH's] position is that the law doesn't extend to inpatient care. That isn't a question of policy, but rather of the law itself. If there is going to be a policy change, then Congress should make the change, not CMS."

Seaberg says that the ACEP "is generally not in favor of [extending EMTALA to the full inpatient experience]. If a patient develops a condition that the hospital can't handle, and another hospital could provide better care to the patient, this new proposal could interfere with that. And there could be gaming."

With all of these worries, it is not surprising that at times there has been mumbling about repealing EMTALA. But that seems to be fantasy. There have not been any serious initiatives in that regard, and even with the pronounced shift to the right in Congress, this doesn't appear to be a priority. Pollack says, "As a practical matter, I don't see political leaders wanting to repeal it. This is not an attractive thing for a politician to advocate."

**What Has Been Its Impact?**

EMTALA has had both good and bad effects. It was and is an unfunded mandate, to be sure; but most hospitals were not in the habit of turning away people with emergency conditions before it was passed. Besides, data on what was going on before EMTALA, compared with what has happened since, are virtually nonexistent, and are usually incompatible when they can be found. The factors that led to its birth were anecdotes and policy concerns, not data.
Certainly, emergency department visits have skyrocketed since its passage, from 77 million in 1986 to 127 million in 2009, according to the AHA (the CDC estimates the total of 2009 visits at 117 million; scholars differ). But the population of the United States has grown markedly since 1986, and there was no huge bump in ED visits in 1987 or 1988, after EMTALA went into effect; the increase has been remarkably steady, at 3 to 5 million a year.

Emergency department crowding, especially in cities, certainly has emerged as a patient care and policy issue, but how much of that can be attributed to EMTALA is uncertain. As other avenues to care shrink, disappear or become unaffordable in a tough economy, the ED becomes the only possible option. And although many patients probably could rearrange their lives to seek care in other settings, the ED is still a theoretically convenient, 24/7 site of care — although the fact that many people must wait there for hours raises the question of just how convenient it is. A recent study found that one in five patients who go to EDs in California leaves without being evaluated at all, and there is no telling how sick these people may be.

In addition, some hospitals have dealt with EMTALA by avoiding any exposure to it in the first place. Gage says that he believes the law led to the closing of some EDs, especially in California. He also points out that physician- or investor-owned specialty for-profit hospitals do not generally have EDs at all, although he emphasizes that EMTALA is not the major factor in that practice.

Both Anderson and Gage add that this law allowed safety-net hospitals and other providers to create responsible arrangements for patient transfers and to establish something of a level playing field when it comes to patients in extreme need. In Gage's words, "EMTALA's real value is that it has enabled safety-net hospitals to establish regional and communitywide protocols for acceptable behavior, which some private hospitals might not have been willing to develop. The result has been a whole lot less dumping and a whole lot more appropriate transferring of patients."

How many lives has it saved? Who knows? To put it mildly, it would be a bit tricky to determine that. As Hinsdale says, "You can't really do a scientific study, but it's so obvious. We know it has saved many lives." Anderson adds that because of EMTALA, people seek care earlier, which protects lives, prevents disability and saves money.
And, in some ways, perhaps the law's most important impact, according to Wendy Mariner, J.D., M.P.H., professor of health law at the Boston University School of Public Health, was that EMTALA represented the first time that anyone other than prison inmates (who have a constitutional right to care, no matter how callously that is ignored) gained an affirmative right to treatment. "Before EMTALA, patients only had rights if they were already in care in hospitals. They had the right to refuse treatment, the right to have their personal medical information kept confidential, the right to change physicians, and the right to walk away, but they had no right to care in the first place. This was the first recognition of a patient's general legal right to receive health care," Mariner says.

Unanswered Questions
Questions remain, of course. Perhaps the most critical is whether this is the best we can do. As the health care reform express rushes forward and enthusiasm blossoms in every corner for integrated delivery systems, electronic health records, accountable care organizations and medical homes, EMTALA remains the principal lifeline for tens of millions of patients who have been left behind.

"One of the challenges we face," says Pollack, "is that the ED ends up being the place where all the things at which society fails come because of the lack of any alternative. The hospital becomes the last resort for care — the family doctor for the uninsured. And in certain cities, when police are frustrated with mentally ill or homeless people, they just drop them off at the ED. Hospitals are at the receiving end of society's problems."

And it is an expensive, fragmented, uncoordinated way to take care of people. Anderson says, "Failure to get uninsured poor people into systems of care poses the same moral dilemma [as dumping] — with a different pinstripe." Gage adds, "By the time someone is in emergency care, the system has failed because it has not found them earlier."

A Sea Change
Nevertheless, it is beyond argument that EMTALA has changed the culture of the emergency department. Anderson says, "Maybe some of it is fear — no one wants to pay $25,000 or $50,000 for each incident. But I also think the law fundamentally changed how people think and behave. There is now a general belief that dumping unstabilized patients is not acceptable, morally or otherwise. I think it may well have changed the culture of emergency departments nationally. Young doctors don't even think about this any more; it's not something they even consider."
Hinsdale agrees: "Doctors just coming out of medical school or emergency training today have no idea of the kind of archaic practice mode that prevailed 30 years ago, when you had to show up in the ER with something in your wallet, and you were asked about that money before you got in the door. If you didn't have anything in your wallet, you were told to go elsewhere."

If the days of the wallet biopsy are over, few would mourn their passing. A most relevant example occurred in Tucson, Ariz., on Jan. 8, when an apparently deranged gunman killed six people and injured 13 others, including U.S. Congresswoman Gabrielle Giffords (D-Ariz.). Among the dead was federal district judge John Roll. In the Feb. 3 issue of The New York Times, Peter Rhee, M.D., chief trauma surgeon at University Medical Center in Tucson, where the victims were taken, said that Giffords received the same care there as any other gunshot victim. "We don't have time or luxury to ask for insurance cards or to know if they are a good guy or how they are going to pay,' he said. "We deal with whoever comes in the door. We don't know if they are immigrants, if they are legal, illegal. We just treat them.'"

It would be nice if hospitals could get properly reimbursed for that. It would be nice if everyone had coverage so the question didn't even come up. But if EMTALA has accomplished nothing else, it has created a safe haven for those who fall through the cracks, or who have nowhere else to go at that time of day or night, or — gosh! — those patients who have serious emergency medical conditions and need immediate care.

Mariner concludes, "EMTALA changed the baseline. It changed the expectations of both patients and physicians, and the concept of what people are entitled to." And from Anderson, who fought so hard and for so long to do something about the dumping of unstabilized patients: "I think getting EMTALA passed may be the most important thing we ever did. It was and is a moral imperative."

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Emily Friedman is an independent writer, speaker and health policy and ethics analyst based in Chicago. She is also a regular contributor to H&HN Daily and a member of the Center for Healthcare Governance's Speakers Express service. Emily can be contacted through her website www.emilyfriedman.com

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