

America's Unraveling Safety Net: EMTALA's Effect on Emergency Departments, Problems and Solutions

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Tristan Dollinger, *America's Unraveling Safety Net: EMTALA's Effect on Emergency Departments, Problems and Solutions*, 98 Marq. L. Rev. 1759 (2015).

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AMERICA’S UNRAVELING SAFETY NET: EMTALA’S EFFECT ON EMERGENCY DEPARTMENTS, PROBLEMS AND SOLUTIONS

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I. INTRODUCTION

Throughout most of the twentieth century, the decision to treat a patient was up to a hospital's discretion.¹ The primary function of hospitals was originally rooted in servicing the poor; however, the primary function of hospitals changed during the twentieth century due to a number of developments in the American health care system.² Hospitals now serve as the "epicenters of medical care" for everyone.³ The increased demand for hospital services throughout the twentieth century led to increased costs for providing health care, and hospitals were forced to shift their focus to patients who could pay their hospital bills as a means for subsidizing the increased costs of care for the poor.⁴ This necessary shift in focus, in conjunction with changes in the way society paid for health care, particularly Medicare's adoption of a prospective payment system (PPS) in 1983, led to a phenomenon called "patient dumping" during the 1980s.⁵ Patient dumping is when a hospital refuses to treat a person in need of emergency medical treatment because of the person's uninsured status or inability to pay.⁶

Congress responded to patient dumping by passing the Emergency Medical Treatment and Labor Act (EMTALA) in 1986.⁷ EMTALA

1. Alexa E. Welzien, *Balancing EMTALA's Duty to Stabilize Hospital Inpatients and CMS's Regulations in the Midst of A Struggling Hospital Industry*, HEALTH LAW., Aug. 2011, 21, at 21 (2) ("[H]ospitals had no affirmative duty to treat patients and could simply choose which patients to serve and which to refuse without any given reason."). Private hospitals and many public hospitals certainly had discretion in choosing whom to treat; although it should be noted that public hospitals accepting funds for new hospital construction under the Hill-Burton Act of 1946 were required to provide assurances that they would provide "a reasonable volume of services to persons unable to pay" in the new or updated facility. 42 U.S.C. § 291c(e) (2012). Hospitals accepting funding under the Hill-Burton Act did not have an affirmative duty to treat all indigent persons though; rather, they were only required to promise to treat "a reasonable volume" of indigent persons. *Id.* Additionally, the Act provided an exception from this required promise if it was "not feasible from a financial viewpoint" for the hospital. *Id.* Therefore, even public hospitals that received funding under the Hill-Burton Act retained some discretion in accepting patients. For a more detailed discussion of the common law no-duty rule and Hill-Burton Act, see Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1191–92, 1196–201 (1986).

2. Welzien, *supra* note 1, at 21–22; *see also* Treiger, *supra* note 1, at 1191–96.

3. Welzien, *supra* note 1, at 21–22.

4. *See id.* at 22; *see also* Treiger, *supra* note 1, at 1192–96.

5. Welzien, *supra* note 1, at 22.

6. *See infra* notes 126–28 and accompanying text.

7. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2012)).

requires hospital emergency departments (EDs) to screen and provide necessary stabilization to anyone who requests an exam, regardless of his or her ability to pay.⁸ By requiring EDs to provide emergency medical care to everyone, the Act created a national health care safety net; however, the Act does not include a mechanism for funding this required care, which has resulted in several unintended consequences.⁹

The legislative history is clear that members of Congress intended EMTALA to prohibit patient dumping,¹⁰ but the language of the statute has resulted in a broader application of the statute than it seems the Legislature intended.¹¹ The inconsistency between the legislative history of the Act and the plain meaning of its text divided the courts in the years after EMTALA's enactment.¹² In an attempt to balance the Act's legislative history and the plain meaning of its text, the Sixth Circuit adopted an "improper motive requirement" for claims involving a violation of EMTALA's medical screening requirement.¹³ Thus far, the Sixth Circuit stands alone amongst the federal appellate courts in adopting this improper motive requirement.

The combination of EMTALA's application to everyone, its lack of funding, and the shift in health care reimbursement to a PPS has placed an ever-increasing financial burden on hospitals.¹⁴ This burden takes an even greater toll on hospitals with safety net EDs, because safety net EDs provide services to a disproportionate number of uninsured and underinsured individuals.¹⁵ America's health care safety net is unraveling—hospitals and EDs close each year as a result of Medicare

8. 42 U.S.C. §§ 1395dd(a)–(b) (2012).

9. See *infra* notes 66–68 and accompanying text.

10. See *infra* Part III.A.

11. See *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 270 (6th Cir. 1990) (“[The plain meaning of EMTALA’s text] leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of.”); see also Victoria K. Perez, Comment, *EMTALA: Protecting Patients First by Not Deferring to the Final Regulations*, 4 SETON HALL CIRCUIT REV. 149, 174 (2007); 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, 1515 (1995); 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, 1122 (1992).

12. See *infra* Part IV.A.

13. See *infra* Part IV.B.

14. See *infra* Part II.A.

15. See *infra* note 74 and accompanying text.

and Medicaid payment shortfalls and the uncompensated care costs created by EMTALA.¹⁶

In addition to the financial burden EMTALA places on hospitals, the Act also contributes to the problem of ED overcrowding.¹⁷ ED overcrowding adversely affects the quality of care hospitals provide to all their patients, insured and uninsured alike.¹⁸

Other commentators have remarked upon the financial problems facing hospitals¹⁹ and the Sixth Circuit's improper motive requirement.²⁰ Some commentators have even proposed amending EMTALA to make the statute's language consistent with its legislative history.²¹ This Comment distinguishes itself by (1) examining the problems facing hospitals and EDs in a new manner; (2) proposing amendments to address the problems facing hospitals with EDs, the current circuit split, and the discrepancy between EMTALA's legislative history and the plain meaning of its text; and (3) discussing the unique ramifications of these amendments.

This Comment proposes amendments to EMTALA that limit the Act's coverage to indigent or uninsured persons and clarifies its intended purpose—stopping patient dumping. Adoption of these amendments to EMTALA will accord the Act's text with its legislative history, resolve the current circuit split, and partially remedy EMTALA's unintended consequences. Alternatively, this Comment

16. See *infra* Part II.

17. See *infra* Part II.B.1.

18. See INST. OF MED., HOSPITAL-BASED EMERGENCY CARE: AT THE BREAKING POINT, at xv (2007).

19. See generally Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden It Places on Hospitals*, 7 J.L. SOC'Y 146 (2005) (examining the financial burden placed on EDs by EMTALA for the treatment of undocumented aliens); Samuel R. Maizel & Craig Garner, *The Poor Get Poorer: The Fate of Distressed Hospitals Under the Affordable Care Act*, NORTON BANKR. L. ADVISER, Dec. 2012, at 1 (2012) (examining the effects of the ACA on financially distressed hospitals); Erik J. Olson, Note, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449 (1994) (examining the quality of care and fiscal issues facing EDs and proposing a system of primary care centers).

20. See generally Wendy W. Bera, Comment, *Preventing "Patient-Dumping": The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA*, 36 HOUS. L. REV. 615, 629–35 (1999) (detailing the Supreme Court's decision regarding the Sixth Circuit's improper motive requirement); Stricker, *supra* note 11, at 1149–56 (proposing amendments to EMTALA limiting its application to instances where an "improper economic motive is present.").

21. See Smith, *supra* note 11, at 1534–37 (proposing amendments to EMTALA limiting the Act's application to uninsured and indigent persons).

argues that adoption of the Sixth Circuit's improper motive requirement for claims alleging a violation of EMTALA's medical screening requirement will result in case decisions more in line with the original intent of the Legislature and reduce the number of improper EMTALA claims. This in turn will reduce some of the fiscal pressure being placed on EDs today.

Part II of this Comment outlines some of the problems facing EDs that EMTALA exacerbates. Part III examines EMTALA in greater detail, including its legislative history and statutory language. Part IV discusses the judiciary's application of the statute, including the division between the courts, the Sixth Circuit's improper motive requirement, and the only Supreme Court decision to date interpreting EMTALA. Part V offers three suggestions that could remedy the inconsistency between EMTALA's legislative history and its text, resolve the circuit split, and reduce some of the problems confronting EDs.

II. PROBLEMS AFFECTING EDs EXACERBATED BY EMTALA

Since EMTALA's enactment the number of visits to hospital EDs has steadily increased.²² For example, in 1991 there were 88.5 million ED visits, and by 2011 the number of ED visits had increased to 129.5 million.²³ According to a 2007 Institute of Medicine (IOM) report, "[b]etween 1993 and 2003, the population of the United States grew by 12 percent . . . and ED visits rose by more than 2 million per year from 90.3 to 113.9 million—a 26 percent increase."²⁴ These figures are quite clear that population growth alone does not account for the increased use of EDs.²⁵

While EDs experienced a growing number of visits, the number of uninsured persons in the United States grew from 35.4 million (14.1% of the population) in 1991 to 48.6 million (15.7% of the population) in

22. See AM. HOSPITAL ASS'N, TRENDWATCH CHARTBOOK 2013: TRENDS AFFECTING HOSPITALS AND HEALTH SYSTEMS, at A-28 (2013) [hereinafter TRENDWATCH CHARTBOOK] (reporting the number of emergency department visits annually from 1991 through 2011, including but not limited to 88.5 million in 1991, 94.7 million in 1995, 103.1 million in 2000, 114.8 million in 2005, and 129.5 million in 2011).

23. *Id.* (reporting that in 1991 there were 88.5 million ED visits or 351 visits per every 1,000 people, and in 2011 there were 129.5 million ED visits or 415 visits per every 1,000 people).

24. INST. OF MED., *supra* note 18, at 2.

25. See *id.*; see also LINA CHOUDHRY ET AL., THE IMPACT OF COMMUNITY HEALTH CENTERS & COMMUNITY-AFFILIATED HEALTH PLANS ON EMERGENCY DEPARTMENT USE 1 (2007).

2011.²⁶ The Congressional Budget Office (CBO) estimated the number of uninsured reached 55 million in 2013.²⁷ Although uninsured persons are not the sole cause of the growth in ED visits, due to EMTALA they are definitely a contributing cause.²⁸

EMTALA's enactment resulted in hospital EDs becoming the only point of access in America's health care system that serves all patients regardless of their ability to pay, which lead to EDs becoming the nation's main health care safety net.²⁹ According to the IOM,

“[C]ore safety net providers” [have] two distinguishing characteristics: 1) either by legal mandate or explicitly adopted mission they maintain an “open door,” offering access to services for patients regardless of their ability to pay; and 2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.³⁰

As a result of being the main health care safety net for a nation experiencing growth in both the number of ED visits and its uninsured population, EDs are under increasing financial pressures and suffering from overcrowding.³¹

26. TRENDWATCH CHARTBOOK, *supra* note 22, at A-10.

27. CONG. BUDGET OFFICE, EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE, MAY 2013 BASELINE, at tbl.1 (2013), available at <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2013-05-ACA.pdf>, archived at <https://perma.cc/E7R5-PNKD>. This figure “includes unauthorized immigrants as well as people who are eligible for but not enrolled in Medicaid” and are under the age of 65. *Id.* The CBO estimated that the number of uninsured would only rise to 55 million in 2013, rather than the previously estimated 57 million under the old law, as a result of the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. *Id.*

28. See INST. OF MED., *supra* note 18, at 3.

29. *E.g., id.* at xv. (“[T]he emergency care system has become the ‘safety net of the safety net,’ providing primary care services to millions of Americans who are uninsured or otherwise lack access to other community services.”); Steven R. Eastaugh, *Overcrowding and Fiscal Pressures in Emergency Medicine*, HOSPITAL TOPICS, Winter 2002, at 7, 8 (“EDs have become the primary healthcare safety net in this country.”); W. Wesley Fields et al., *The Emergency Medical Treatment and Labor Act as a Federal Health Care Safety Net Program*, 8 ACAD. EMERGENCY MED. 1064, 1064 (2001) (“EDs play a vital role as core safety net providers in today’s health care system.”); Renee Y. Hsia, Arthur L. Kellerman & Yu-Chu Shen, *Factors Associated With Closures of Emergency Departments in the United States*, 305 J. AM. MED. ASS’N 1978, 1978 (2011) (“As the only place in the US health care system that serves all patients, [EDs] are the ‘safety net of the safety net.’”).

30. Fields et al., *supra* note 29, at 1064.

31. Researchers have commented that these consequences of EMTALA’s enactment should come as no surprise. See INST. OF MED., *supra* note 18, at xv (“An unintended but predictable consequence of this legal duty [created by EMTALA] is a system that is overloaded and underfunded to carry out its mission.”).

A. *The Fiscal Burden on Hospitals*

To understand the fiscal burden on hospitals, an overview of the general financial landscape hospitals operate within is necessary. Also, the role EMTALA has played in exacerbating this fiscal burden—both as an unfunded mandate and through its direct costs—should be discussed. Finally, the significant ramifications this fiscal burden has specifically on hospitals with EDs needs to be addressed.

1. The General Financial Landscape Hospitals Operate Within

The general financial outlook for many hospitals is rather bleak. This is indicated by the number of hospitals closing over the past few decades.³² In 1991 there were 5,342 community hospitals in the United States, and by 2011 this number decreased seven percent to 4,973.³³ The primary reason for this trend is that hospitals face increasing financial pressures.³⁴ “At least one-quarter to one-third of the hospitals in the United States operate with little or no profit margin”³⁵ From 1995

32. See TRENDWATCH CHARTBOOK, *supra* note 22, at A-20 (reporting the number of community hospitals in the U.S. declining by 7% from 1991 to 2011); Michelle Nicole Diamond, Note, *Legal Triage for Healthcare Reform: The Conflict Between the ACA and EMTALA*, 43 COLUM. HUM. RTS. L. REV. 255, 283 (2011) (“Hospital closure rates skyrocketed in the last decade, especially for public hospitals and hospitals located in heavily uninsured communities.”).

33. TRENDWATCH CHARTBOOK, *supra* note 22, at A-20. The number of urban community hospitals during this period did oscillate; however, the United States experienced a net gain of 68 urban hospitals in this period, therefore the overall loss of 369 community hospitals nationally occurred entirely within the rural community hospital market. *Id.* Between 1991 and 2011, 437 rural community hospitals closed—a loss of 18% of rural hospitals in the U.S. *Id.*

34. See Maizel & Garner, *supra* note 19, at 1 (“Distressed hospitals in America operate on small or non-existent profit margins.”); Diamond, *supra* note 32, at 282 (“Even before Congress passed the ACA, many predicted that the financial pressure from treating undocumented immigrants would increase hospital bankruptcy and closure.”); Anemona Hartocollis, *Other Hospitals Take Up Slack Caused by Closing of St. Vincent’s*, N.Y. TIMES, Apr. 8, 2010, at A29 (describing the vote to close St. Vincent Catholic Medical Centers, “the last full-service Catholic hospital in New York City”) (“The vote came after futile efforts to find a partner that would help run the hospital, which is burdened with \$700 million in debt and is losing millions more every month.”); Nick Madigan, *Los Angeles Emergency Care Crisis Deepens*, N.Y. TIMES, Aug. 21, 2004, at A8 (attributing the closure of Northridge Hospital Medical Center to financial pressures because “the hospital ha[d] been losing \$1 million a month for a year”).

35. Maizel & Garner, *supra* note 19, at 4; see TRENDWATCH CHARTBOOK, *supra* note 22, at 39.

to 2011, the percentage of hospitals with negative operating margins varied between 27.7% and 42.2%.³⁶

To better understand why so many hospitals are operating at a loss, it is helpful to gain a basic understanding of how hospitals are compensated.³⁷ The federal government, state governments, private payers, and patients are the main sources of payment for hospitals.³⁸ Medicare and Medicaid are the main government programs compensating hospitals.³⁹ Medicare is a federal program providing health coverage for people over the age of sixty-five.⁴⁰ Medicaid is a state-administered program which receives at least 50% of its funding from the federal government and provides coverage for health services similar to Medicare.⁴¹ Traditionally, individuals qualified for Medicaid by being sufficiently poor and falling into a particular category, such as being disabled;⁴² however, the Affordable Care Act (ACA) removes the

36. TRENDWATCH CHARTBOOK, *supra* note 22, at A-32 (reporting 27.7% in 1996 and 42.2% in 2000). On average, 32.8% of hospitals experienced negative profit margins during 1995–2011. *See id.*

37. A detailed examination of hospital financing structures and compensation mechanisms is beyond the scope of this Comment. See generally JASON H. SUSSMAN & ERIC A. JORDAHL, A GUIDE TO FINANCING STRATEGIES FOR HOSPITALS WITH SPECIAL CONSIDERATION FOR SMALLER HOSPITALS (2010), for a detailed guide on hospital financing strategies with emphasis on smaller hospitals, and FELIX KAUFMAN, A PRIMER ON HOSPITAL ACCOUNTING AND FINANCE FOR TRUSTEES AND OTHER HEALTHCARE PROFESSIONALS (4th ed. 2009), for a primer providing an overview of healthcare finance, reimbursement, and accounting.

38. KAUFMAN, *supra* note 37, at 7. Private payers includes insurance companies. *Id.*

39. *See* TRENDWATCH CHARTBOOK, *supra* note 22, at 41 (reporting that 9.6–16.3% of hospital costs between 1980 and 2011 were distributed to Medicaid and 34.6–39.3% were distributed to Medicare, as compared to only 1.8–6.1% being distributed to other government programs); *see also* KAUFMAN, *supra* note 37, at 7 (listing only Medicare and Medicaid by name as government programs paying hospitals).

40. KAUFMAN, *supra* note 37, at 8; Lawrence Singer, *Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America*, 36 LOY. U. CHI. L.J. 613, 618–20 (2005) (providing details of the Medicare program).

41. Maizel & Garner, *supra* note 19, at 2 (“Medicaid offers similar access for medical services on a state level for qualifying individuals, many of whom are poor.”); *see* KAUFMAN, *supra* note 37, at 8; Singer, *supra* note 40, at 620–22 (providing details of the pre-ACA Medicaid program).

42. ALISON MITCHELL, CONG. RESEARCH SERV., R42865, MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS 1 (2013) (reporting historical Medicaid eligibility categories to include “low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities”); *see also* David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 331 (2012) (describing Medicaid’s historical income and category requirements); Singer, *supra* note 40, at 620–22 (describing the pre-ACA Medicaid program).

category requirement and expands eligibility to anyone falling below 133% of the federal poverty line.⁴³ In 2012 sixty-eight million Americans were enrolled in Medicaid,⁴⁴ and this number is expected to increase as a result of these eligibility changes.⁴⁵

Since 1980 Medicare and Medicaid have become responsible for a greater percentage of hospital costs each year while private insurance companies' percentage of hospital costs shrink.⁴⁶ "Combined, Medicare and Medicaid pay for more than half of the annual hospital bills in America."⁴⁷

This reliance on Medicare and Medicaid for payment is particularly troubling for hospitals because the compensation rates for both programs are not determined by the market, and subsequently neither program covers all the treatment costs for their enrollees.⁴⁸ Most years Medicare covers a greater portion of its patients' hospital costs than Medicaid;⁴⁹ however, in 2011, Medicare covered 91.4% of hospital costs

43. MITCHEL, *supra* note 42, at 1 (noting that "recent changes [to Medicaid] will soon add coverage for individuals under the age of 65 with income up to 133% of the federal poverty level"); see Orentlicher, *supra* note 42, at 332 ("In 2014, . . . Medicaid finally will become a program for all of the poor (defined as families earning no more than 133% of the federal poverty level)."); *Affordable Care Act*, MEDICAID.GOV, <http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html> (last visited June 11, 2015), available at <http://perma.cc/F3R2-SM6L> (detailing the ACA's changes to Medicaid).

44. TRENDWATCH CHARTBOOK, *supra* note 22, at A-12.

45. See *Affordable Care Act*, *supra* note 43; Caroline F. Pearson, *Analysis: Medicaid Plans Expected to Grow 20% This Year Under ACA Expansion*, AVALERE (Jan. 15, 2014), <http://avalerehealth.net/expertise/managed-care/insights/analysis-medicaid-plans-expected-to-grow-20-this-year-under-aca-expansion>, archived at <http://perma.cc/6PEV-TJPV>; Christine Vestal, *Why New Medicaid Enrollment Is Soaring*, KAISER HEALTH NEWS (Nov. 6, 2013), <http://www.kaiserhealthnews.org/stories/2013/november/06/stateline-medicaid-enrollment-increases-by-state.aspx>, available at <http://perma.cc/ZL9W-SXWX>.

46. TRENDWATCH CHARTBOOK, *supra* note 22, at 41 (reporting hospital cost distributions by payer type: Medicaid 9.6% (1980), 12.8% (2000), and 16.3% (2011); Medicare 34.6% (1980), 38.3% (2000), and 39.3% (2011); and private payers 41.8% (1980), 38.7% (2000), and 34.6% (2011)).

47. Maizel & Garner, *supra* note 19, at 2.

48. *Id.* ("The level at which Medicare and Medicaid reimburse is dictated by legislation and policy, not the market. By most statistics these programs fail to reimburse hospitals even what it costs the hospitals to provide services to the programs' beneficiaries, let alone make a profit."); see KAUFMAN, *supra* note 37, at 7 ("[N]either Medicare nor Medicaid covered all hospital costs for treating their patients.").

49. TRENDWATCH CHARTBOOK, *supra* note 22, at A-35 (reporting that Medicare covered a greater percentage of hospital costs than Medicaid in eighteen years out of twenty between 1991 and 2011); Orentlicher, *supra* note 42, at 333 ("Medicaid pays physicians at lower levels than does Medicare According to a national survey from 1998–2003, Medicaid's reimbursement rates for physicians averaged sixty-two percent of Medicare rates

for Medicare patients, and Medicaid covered 94.7% of hospital costs for Medicaid patients.⁵⁰ The combined Medicare and Medicaid payment shortfalls for that year alone resulted in a loss of nearly \$30 billion to U.S. hospitals.⁵¹ When the programs responsible for paying over half of the hospital bills in the country actually cost hospitals billions of dollars in the aggregate, it should come as no surprise that so many hospitals are operating at a loss.

The losses incurred by hospitals for treating Medicare and Medicaid patients are largely due to the PPS adopted in 1983.⁵² Prior to 1983 a Medicare patient went to a hospital, was treated, and then Medicare would reimburse the hospital for the services it provided and any reasonable costs the hospital incurred in treating the patient.⁵³ This system of receiving payment after services were performed based on the *actual costs* of the treatment administered was referred to as a “retrospective payment system.”⁵⁴ In 1983 Congress changed the way the Medicare program reimbursed hospitals for inpatient services from a

in 1998, rising to sixty-nine percent of Medicare rates by 2003.”); *see also* Singer, *supra* note 40, at 622 (“Medicaid reimbursements for services are exceptionally poor, often covering less than one-half of service costs, and then only after significant delays in payment.”).

50. TRENDWATCH CHARTBOOK, *supra* note 22, at A-35. These figures include Medicare and Medicaid Disproportionate Share Payments. *Id.* For a discussion of Disproportionate Share Payments, *see supra* notes 74–82 and accompanying text.

51. TRENDWATCH CHARTBOOK, *supra* note 22, at A-36.

52. *See* Welzien, *supra* note 1, at 22 (“In 1983 Congress restructured how the federal government’s Medicare program paid for inpatient hospital services. . . . [T]he new structure implemented a [PPS]. . . .”); *see also* KAUFMAN, *supra* note 37, at 9 (“A new set of legislative initiatives resulted in the [PPS] for Medicare in 1983.”). Although the 1983 legislative changes were to the Medicare program specifically, Medicaid programs adopted the PPS approach in 1986, as did private insurance companies in the latter half of the 1980s. KAUFMAN, *supra* note 37, at 9. Accordingly, the following description of the PPS appropriately describes the system currently in place for Medicare, Medicaid, and private payer reimbursement to hospitals.

53. *See* Welzien, *supra* note 1, at 22 (“The previous structure involved a retrospective payment system in which Medicare reimbursed the hospitals for the services and expenditures that the hospital incurred in treating the Medicare beneficiary. The hospital simply used whatever resources were necessary to treat the patient, and after providing treatment would receive reimbursement for any reasonable costs incurred and services provided.” (footnote omitted)).

54. *Id.* (“The previous structure involved a retrospective payment system in which Medicare reimbursed the hospitals for the services and expenditures that the hospital incurred in treating the Medicare beneficiary.”).

retrospective payment system to a PPS⁵⁵—the system which remains in place today.

Under the PPS not much changed from the patient's prospective. The Medicare patient still goes to a hospital and is diagnosed, treated, and discharged similar to the old system.⁵⁶ The change occurs once the patient is discharged, at which point the hospital assigns the patient to a Diagnosis Related Group (DRG) according to the patient's diagnosis and the procedures performed by the hospital.⁵⁷ Each DRG has a *predetermined amount* that Medicare reimburses the hospital based upon *estimated costs of treatment* for the DRG.⁵⁸ If the actual cost of treatment is less than the DRG's predetermined amount, the hospital keeps the excess.⁵⁹ If, on the other hand, the actual cost of treatment is greater than the predetermined amount, the hospital loses money.⁶⁰ Considering the billions of dollars in payment shortfalls to hospitals from Medicare and Medicaid annually, it is safe to say that many hospitals lose more money under the PPS than they make in excess of their costs.

As if the financial burden placed on hospitals by Medicare and Medicaid was not enough, EMTALA exacerbates hospitals' financial problems by virtue of being an unfunded mandate.

2. The Costs of EMTALA Being an Unfunded Mandate

Medicare and Medicaid payment shortfalls are problems that all hospitals must contend with; however, the financial troubles affecting

55. *Id.* (“In 1983 Congress restructured how the federal government’s Medicare program paid for inpatient hospital services. The previous structure involved a retrospective payment system [T]he new structure implemented a [PPS]”).

56. *See supra* note 53 and accompanying text.

57. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH AND HUMAN SERVS., ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM: PAYMENT SYSTEM FACT SHEET SERIES 2 (2013) (“Discharges are assigned to diagnosis-related groups (DRG), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay.”). A patient’s assigned DRG is determined on the basis of a “principal diagnosis and up to 24 secondary diagnoses,” *Id.* In 2011 there were 745 DRGs which patients could be classified under. *See Welzien, supra* note 1, at 22.

58. Welzien, *supra* note 1, at 22. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 57, at 3–5 (detailing the Inpatient PPS’s payment rates and how they are set).

59. Welzien, *supra* note 1, at 22.

60. *Id.*

hospitals are even more acute for those with EDs.⁶¹ During 1991–2011 EDs closed at greater rates than hospitals.⁶² Specifically, there were 5,108 EDs operating in 1991, and by 2011 that number had dropped to 4,461—a loss of 647 EDs (12.7%) nationwide.⁶³ A recent study found “economic drivers [to be] associated with ED closures.”⁶⁴ One news article even reported that seventy EDs and trauma centers in California alone closed between 1990 and 2004 due in part to underfinancing.⁶⁵

The financial troubles leading to ED closures are due in large part to EMTALA being an unfunded mandate.⁶⁶ EMTALA requires EDs to provide medical screenings and stabilizing treatment to uninsured and indigent patients⁶⁷ but does not provide any federal funding to pay for this care.⁶⁸ In 2011, 48.6 million people—15.7% of the U.S. population—were uninsured.⁶⁹ That same year hospitals lost \$41.1 billion dollars from providing uncompensated care to the uninsured.⁷⁰ From 1986—the year EMTALA was promulgated—through 2011, hospitals lost \$573.5 billion from providing uncompensated care to the

61. See Eastaugh, *supra* note 29, at 7, 11 (“The emergency department is seen as a financial weak spot If a hospital closes its ED, it reduces those financial losses. . . . [¶] Emergency departments in America are disappearing at an alarming rate. Those that remain face . . . budgetary shortfalls.”).

62. See TRENDWATCH CHARTBOOK, *supra* note 22, at A-20, A-28.

63. *Id.* at A-28. Compared to the loss of 7% of hospitals during this same time period. See *supra* note 33 and accompanying text.

64. Hsia et al., *supra* note 29, at 1983 (“Our nationwide analysis of ED closures between 1990 and 2007 identified several risk factors that suggest economic drivers are associated with ED closures. Hospital-specific characteristics related to higher risk of closure were safety-net status, for-profit ownership, and low profit margin.”).

65. Madigan, *supra* note 34.

66. See, e.g., Fields et al., *supra* note 29, at 1064 (referring to EMTALA as an unfunded mandate); Katherine Diaz Vickery, Kori Sauser & Matthew M. Davis, *Policy Responses to Demand for Health Care Access: From the Individual to the Population*, 309 J. AM. MED. ASS’N 665, 665 (2013) (referring to EMTALA as “an unfunded mandate for provision of emergency care”).

67. 42 U.S.C. § 1395dd(a)–(b) (2012).

68. See *id.* § 1395dd (containing no funding provision for the care it mandates).

69. TRENDWATCH CHARTBOOK, *supra* note 22, at A-10.

70. AM. HOSPITAL ASS’N., AMERICAN HOSPITAL ASSOCIATION: UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 3 (2013). Uncompensated care cost is a combination of a hospital’s charity care and bad debt. *Id.* at 2. It is appropriate to combine charity care and bad debt because “[b]ad debt is often generated by medically indigent and/or uninsured patients”; therefore, there is no meaningful distinction between the two categories. *Id.*

uninsured.⁷¹ These losses are *apart from* the Medicare and Medicaid payment shortages previously discussed.⁷²

National data indicates uninsured patients visit EDs proportionate to or slightly higher than their percentage of the population;⁷³ however, this national data does not paint a full picture. Some EDs—*safety net EDs*—“provide a disproportionate share of services to Medicaid and uninsured persons.”⁷⁴ In 2007, approximately two thirds of all EDs were classified as safety net EDs due to the increasing number of uninsured and Medicaid patients visiting EDs in the late 1990s and 2000s.⁷⁵ By virtue of providing services to a disproportionate amount of uninsured and Medicaid patients, these safety net EDs burden themselves with a disproportionate share of uncompensated care costs.⁷⁶ According to a recent study, along with these additional costs comes the increased risk of being forced to close their EDs.⁷⁷

In recognition of the additional financial burden safety net hospitals are under, Congress established Medicaid Disproportionate Share

71. *See id.* at 3.

72. *Id.* at 1 (“Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.”).

73. *Compare* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-347, HOSPITAL EMERGENCY DEPARTMENTS: CROWDING CONTINUES TO OCCUR, AND SOME PATIENTS WAIT LONGER THAN RECOMMENDED TIME FRAMES 39 (2009) (reporting self-pay and no charge/charity patients accounting for 16% of ED visits in 2001, 15% in 2002, 15% in 2003, 17% in 2004, 17% in 2005, and 17% in 2006), *with* TRENDWATCH CHARTBOOK, *supra* note 22, at A-10 (reporting 14.6% uninsured in 2001, 15.2% in 2002, 15.6% in 2003, 14.9% in 2004, 15.3% in 2005, and 15.8% in 2006).

74. Ning Tang et al., *Trends and Characteristics of US Emergency Department Visits, 1997–2007*, 304 J. AM. MED. ASS'N 664, 664 (2010) (“Among all EDs, the Centers for Disease Control and Prevention (CDC) further identified a subset as safety-net EDs because these EDs provide a disproportionate share of services to Medicaid and uninsured persons. Specifically, safety-net EDs are facilities that provide more than 30% of total ED visits to persons with Medicaid, more than 30% of total ED visits to uninsured individuals, or a combined Medicaid and uninsured patient population greater than 40%.”).

75. *See id.* at 668 (“Because of the increasing numbers of visits by persons with Medicaid or no insurance, EDs classified as safety net increased 46% during this time period and now constitute almost two-thirds of all EDs.”). According to the CDC, 1,770 EDs (43% of all EDs) were classified as safety net EDs in 2000, and this number grew to 2,489 EDs (63% of all EDs) by 2007. *Id.* at 667.

76. *See* MITCHEL, *supra* note 42, at 1–2.

77. Hsia et al., *supra* note 29, at 1980 (reporting safety net EDs had 50% chance of remaining open after the study period, and non safety-net EDs had 74% chance of remaining open). Other factors that the study determined increase the chance of ED closure include low profit margins, for-profit status, and serving uninsured communities. *Id.* at 1981, 1983–84.

Hospital (DSH) payments in 1981⁷⁸ and Medicare DSH payments in 1985.⁷⁹ The purpose of both DSH payment programs is to reduce the economic losses hospitals suffer as a result of caring for a disproportionate number of Medicaid or Medicare patients, respectively, and uninsured patients.⁸⁰ While Congress had the right idea in creating DSH payment programs—providing additional funding for hospitals suffering the greatest financial losses for caring for the uninsured and underinsured—the DSH system is simply inadequate to handle the amount of losses hospitals suffer from payment shortfalls.⁸¹ Since DSH payments do not even amount to the level of Medicare and Medicaid payment shortages to qualifying hospitals,⁸² it would be incorrect to view the DSH payments as funding EMTALA-mandated services.

78. See MITCHEL, *supra* note 42, at 2 (“Medicaid DSH payments were established in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) The inclusion of this Medicaid DSH provision . . . recognized that hospitals serving disproportionate share of low income patients are particularly dependent on Medicaid payments because low income patients are mostly Medicaid enrollees and uninsured individuals. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance.” (citation omitted)). See generally *Medicaid Disproportionate Share Hospital (DSH) Payments*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html> (last visited June 11, 2015), available at <http://perma.cc/R64P-9VQ6> (government website pertaining to Medicaid DSH payments).

79. *Disproportionate Share Hospital (DSH)*, CMS.GOV, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html> (last modified May 14, 2015, 1:58 PM), available at <http://perma.cc/ZVK3-M47S> (“The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986.”); see also CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 57, at 2 (providing a brief overview of how hospitals qualify for Medicare DHS adjustment). For a detailed explanation of the DSH payment system, see generally MITCHEL, *supra* note 42, at 1–2, and COREY DAVIS, NAT’L. HEALTH LAW PROGRAM, Q&A: DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AND THE MEDICAID EXPANSION 1 (2012) (comparing the Medicaid and Medicare DSH programs).

80. See MITCHEL, *supra* note 42, at 1–2; DAVIS, *supra* note 79, at 1.

81. See Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 168 (2004).

82. See DAVIS, *supra* note 79, at 2–3 (detailing the payments made by both the Medicare and Medicaid DSH payment programs); MITCHEL, *supra* note 42, at 4–7 (2013) (explaining that DSH allotments are the maximum amount of funds that a state can receive for DSH payments and “[e]ach state’s allotment can be no more than the greater of the prior year’s allotment or 12% of its total Medicaid medical assistance expenditures”).

Unfortunately the ACA does not offer a solution for these payment shortfalls to hospitals from Medicare and Medicaid; in fact the problem is only poised to get worse,⁸³ especially for hospitals with safety net EDs that rely upon DSH payments.⁸⁴ The ACA includes a number of provisions cutting payments for health care costs.⁸⁵ One of the largest areas of health care funding scheduled to be cut is DSH funding: Medicare DSH funding is scheduled to be cut by 75%⁸⁶ and Medicaid DSH funds will be reduced by \$18.1 billion between 2014 and 2020.⁸⁷

The rationale behind the DSH funding cuts is that the ACA's individual mandate will result in a substantial number of previously uninsured individuals becoming insured, which will then decrease hospitals' uncompensated care costs.⁸⁸ This rationale is problematic because it overlooks the significant portion of uncompensated care costs created by uninsured undocumented immigrants, who will remain uninsured under the ACA.⁸⁹ By reducing the only source of funding that even attempts to lessen the financial impact of EMTALA's mandated care, Congress is ensuring that EMTALA remains an unfunded mandate and hospitals will continue to struggle financially. While the bulk of the financial problems EMTALA creates for EDs are in the form of uncompensated care costs, EMTALA also places direct costs on hospitals.

83. See Orentlicher, *supra* note 42, at 335–36 (“But ACA does not address important problems with Medicaid. . . . ACA almost guarantees that Medicare will cut reimbursement rates.”); Diamond, *supra* note 32, at 283 (“Although the ACA did not single-handedly create hospital financial difficulty, it exacerbates the problem to the point of widespread medical crisis.”).

84. See DAVIS, *supra* note 79, at 4–6 (providing a brief overview of the ACA's changes to both DSH payment programs); MITCHEL, *supra* note 42, at 10–11 (detailing the ACA's Medicaid DSH payment reductions).

85. Diamond, *supra* note 32, at 266 (“[T]he ACA implements provisions to reduce the amount of money the United States spends on healthcare each year.”); see Maizel & Garner, *supra* note 19, at 2 (“Unfortunately, the Affordable Care Act provides for approximately \$155 billion in cuts in hospital payments over the coming decade.”).

86. DAVIS, *supra* note 79, at 4 n.22, 5; Diamond, *supra* note 32, at 266–67.

87. 42 U.S.C. § 1396r-4(f)(7) (2012); see DAVIS, *supra* note 79, at 4 n.22.

88. DAVIS, *supra* note 79, at 4; MITCHEL, *supra* note 42, at 10–11; Diamond, *supra* note 32, at 267.

89. See Maizel & Garner, *supra* note 19, at 3; Diamond, *supra* note 32, at 257–58, 271–86 (detailing the conflict between the ACA and EMTALA regarding the cost of care for undocumented immigrants). See generally Lebedinski, *supra* note 19.

3. EMTALA's Direct Costs to Hospitals

EMTALA imposes direct costs to hospitals for violation of the statute beyond the uncompensated care costs to EDs arising from EMTALA being an unfunded mandate. These direct costs include civil monetary penalties, termination of Medicare participation, and liability under a private cause of action.⁹⁰

The maximum civil penalty for a hospital is either \$25,000 or \$50,000 per violation depending on the number of beds the hospital has.⁹¹ A hospital that violates EMTALA may also be excluded from participating in the Medicare program.⁹² Between 1986 and 2001, 13 hospitals were excluded from participating in the Medicare program due to EMTALA violations.⁹³ The maximum civil penalty for physicians who negligently violate the statute is \$50,000 per violation.⁹⁴ Physicians that grossly, flagrantly, or repeatedly violate the statute can be excluded from participating in state or federal medical reimbursement programs.⁹⁵

The statute also creates a private cause of action for medical facilities financially injured from an improper transfer to their facility and for "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation" of an EMTALA requirement.⁹⁶ The statute of limitations is two years from the time of the violation.⁹⁷ Hospitals incur a financial loss anytime a suit is brought for an EMTALA violation regardless of whether or not the hospital ED is found guilty of an EMTALA violation: if the hospital is guilty it must pay the judgment in addition to its own litigation expenses, and if the hospital is found not guilty it will still incur financial losses in the form of litigation expenses.

90. 42 U.S.C. § 1395dd(d) (2012).

91. *Id.* § 1395dd(d)(1)(A). The maximum civil monetary penalty is \$50,000 unless the hospital has less than 100 beds, in which case the maximum civil monetary penalty is \$25,000. *Id.*

92. *See id.* § 1395dd(d)(3); OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 6-8 (2001) (detailing the enforcement mechanisms for EMTALA).

93. OFFICE OF INSPECTOR GEN., *supra* note 92, at 8.

94. 42 U.S.C. § 1395dd(d)(1)(B).

95. *Id.*

96. *Id.* § 1395dd(d)(2).

97. *Id.* § 1395dd(d)(2)(C).

4. Ramifications of Fiscal Burden for EDs

In recent years this increased financial burden has been a substantial factor leading to the closure of many EDs, which in turn has placed a greater financial burden on those EDs remaining in operation.⁹⁸ As more hospitals and EDs close, their patients are forced to seek care at the remaining hospitals and EDs.⁹⁹ This reallocation of patients includes a reallocation of uninsured patients along with the cost of their care.¹⁰⁰ The hospitals that were barely getting by¹⁰¹ will be unable to absorb the additional uncompensated care costs for their new uninsured patients and eventually will be forced to close their ED or the hospital in general, and so the cycle will continue. If EMTALA remains as an unfunded mandate, the end result will be too few EDs to appropriately handle the health care needs of both insured and uninsured alike.¹⁰² In addition to the financial burden EMTALA places on hospitals with EDs leading to this cycle of ED and hospital closures, EMTALA also contributes to quality of care problems in those EDs remaining open—specifically, EMTALA is a contributing cause of ED overcrowding.

B. ED Overcrowding

As the nation's health care safety net, EDs have suffered from and continue to battle overcrowding.¹⁰³ In March 2010, over a third of all hospitals reported their ED being at or over capacity.¹⁰⁴ Capacity issues

98. See, e.g., Hartocollis, *supra* note 34 (commenting upon the additional pressures placed on other area hospitals as a result of St. Vincent's closing).

99. See *id.*

100. See Madigan, *supra* note 34.

101. See generally Maizel & Garner, *supra* note 19 (discussing hospitals operating at low or negative profit margins).

102. See INST. OF MED., *supra* note 18, at xv.

103. See, e.g., CHOUDHRY ET AL., *supra* note 25, at 1 (“Demand for ED visits is on the rise and EDs are becoming overcrowded . . .”); Robert W. Derlet & John R. Richards, *Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects*, 35 ANNALS EMERGENCY MED. 63, 63 (2000) (“[T]he issue of overcrowding in emergency departments has become a significant national problem.”); Eastaugh, *supra* note 29, at 11 (“[Emergency departments] that remain face a daily ordeal of overcrowding and budgetary shortfalls.”); Manya F. Newton et al., *Uninsured Adults Presenting to US Emergency Departments: Assumptions vs Data*, 300 J. AM. MED. ASS'N 1914, 1914 (2008) (“Emergency Departments . . . today are in crisis, facing significant overcrowding, unreimbursed care, and long waiting times.”); Philip J. Hilts, *Many Exit Emergency Room Before Getting Needed Care*, N.Y. TIMES, Aug. 27, 1991, at A18.

104. TRENDWATCH CHARTBOOK, *supra* note 22, at 33.

were worse for urban hospitals, half of which reported their ED being at or over capacity at that time.¹⁰⁵

ED overcrowding is a multifactorial problem facing our nation's emergency health care system.¹⁰⁶ Commonly cited factors contributing to ED overcrowding include frequent-flyer patients, increased patient volume, non-urgent visits, inadequate staffing, hospital bed shortages, inpatient boarding, and EMTALA.¹⁰⁷

1. EMTALA's Contribution to ED Overcrowding

The passage of EMTALA opened the doors of EDs to America's uninsured,¹⁰⁸ many of whom began using the ED as they would a primary care facility.¹⁰⁹ Conservatively, one-third of all ED visits in the mid-2000s were for conditions that could be treated in a primary care setting.¹¹⁰ Using an ED in this manner is a *misuse* of the ED.¹¹¹ Studies

105. *Id.*

106. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 73, at 9 ("In terms of factors that contribute to crowding, we reported that crowding is a complex issue and no single factor tends to explain why crowding occurs."); Derlet & Richards, *supra* note 103, at 64 ("ED overcrowding results from multiple complex and often interwoven issues.").

107. See CHOUDHRY ET AL., *supra* note 25, at 1; Derlet & Richards, *supra* note 103, at 64–66 (listing causes of overcrowding to include "increased complexity and acuity of patients presenting to the ED," "overall increase in patient volume," "managed care problems," hospital bed shortages, and staffing shortages (bold font omitted)); Nathan R. Hoot & Dominik Aronsky, *Systemic Review of Emergency Department Crowding: Causes, Effects, and Solutions*, 52 ANNALS EMERGENCY MED. 126, 128–30 (2008) (listing the most commonly studied causes of ED overcrowding as non-urgent visits, frequent-flyer patients, influenza season, inadequate staffing, inpatient boarding, hospital bed shortages); Lisa Belkin, *Houston Faces Crisis in Emergency Care*, N.Y. TIMES, Oct. 22, 1989, at 22.

108. See *infra* Part III.B.

109. See Singer, *supra* note 40, at 625 ("EMTALA incentivizes individuals to seek care at the E.D., because they know they will be seen, even though a less-intensive setting may be more appropriate."); *Emergency in the Emergency Rooms*, N.Y. TIMES, June 21, 2006, at A16; see also Lee, *supra* note 81, at 166 ("Uninsured persons and Medicaid enrollees often seek care in the emergency department, rather than in a physician's office.").

110. CHOUDHRY ET AL., *supra* note 25, at 2 ("At least one-third of all ED visits are 'avoidable' in that they were non-urgent or ambulatory care sensitive . . . and therefore treatable in primary care settings."). Other studies have found the percentage of emergency department visits that were avoidable to be much higher; for example, researchers "found that roughly 75% of all visits to New York City EDs were avoidable, [and] previous studies from the National Center for Health Statistics found that as many as 55% of ED visits were non-urgent." *Id.*

111. The purpose of an ED is to provide immediate medical care to patients suffering from an emergency medical condition; therefore, a patient seeking medical care for a non-emergent medical condition is using the ED contrary to its intended purpose. This understanding of an ED's purpose is suggested by the name *emergency department*.

show that underinsured and uninsured patients misuse EDs in disproportionate numbers.¹¹² This misuse of EDs by the uninsured has contributed to the problem of overcrowding.¹¹³

Although the degree to which uninsured patients are to blame for overcrowding in EDs is debated, there is a consensus that uninsured patients are at least a contributing factor to the problem of ED overcrowding.¹¹⁴ A 2013 study “sought to determine whether EMTALA affects patients’ use of the ED and whether modifying EMTALA might potentially reduce ED utilization.”¹¹⁵ The study found that (1) many patients were aware of the legal obligation that EMTALA created on the part of hospitals, (2) patients that were aware of the legal obligation created by EMTALA were more likely to use the ED, and (3) modification of EMTALA could decrease ED crowding.¹¹⁶

Furthermore, this understanding of an ED’s purpose seems to be Congress’s understanding since EMTALA requires EDs to screen for and, if found, stabilize emergency medical conditions only, not non-emergent medical conditions. *See* 42 U.S.C. § 1395dd(a)–(b) (2012). Even after the enactment of EMTALA, EDs retain the right to turn away patients with non-emergent medical conditions. *Cf. id.*

112. CHOUDHRY ET AL., *supra* note 25, at 2 (“Medicaid beneficiaries and the uninsured also account for more *avoidable* ED visits. EDs serving higher proportions of patients that are Medicaid eligible or uninsured have 25% more non-urgent cases presenting, 10% more emergent conditions presenting that are primary care treatable, and fewer injury and unavoidable emergent conditions presenting compared to other EDs.”); *see* Singer, *supra* note 40, at 622 (discussing the disincentives for health care providers to service Medicaid enrollees).

113. *See* Editorial, *Emergency Room Delays*, N.Y. TIMES, Jan. 19, 2008, at A18 (“Uninsured patients—and those who have no primary care doctor—flock to emergency rooms for routine coverage, clogging the system.”). It stands to reason that if the patients misusing the ED sought care in an appropriate care setting, such as a primary care setting or health center, rather than the ED, then the number of patients in EDs would reduce and not be as overcrowded. *See generally* CHOUDHRY ET AL., *supra* note 25, at 3–5 (discussing studies finding that health centers reduce emergency department visits especially by uninsured and underinsured patients who combined comprised 75.3% of health center patients in 2005).

114. *See* Stephen Zuckerman & Yu-Chu Shen, *Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?*, 42 MED. CARE 176 (2004) (finding that some uninsured adults are frequent ED users and publicly insured adults have the greatest odds of being frequent ED users); Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL’Y 695, 699 (2006) (arguing EMTALA is only a minor factor in ED overcrowding).

115. William M. McDonnell et al., *Does the Emergency Medical Treatment and Labor Act Affect Emergency Department Use?*, 44 J. EMERGENCY MED. 209, 210 (2013).

116. *Id.* at 213 (“[T]he current high degree of public awareness about hospitals’ legal obligations to provide emergency care suggests that EMTALA at least has the potential to affect patients’ emergency care-seeking behaviors. . . . [P]atients aware of EMTALA principles were more likely than other patients to have at least five additional ED visits in a

2. Consequences of Overcrowding

This problem of overcrowding creates quality of care issues in the hospital setting.¹¹⁷ Studies show that ED overcrowding results in adverse patient outcomes, such as increased patient mortality rates.¹¹⁸ Overcrowding also results in delayed patient treatment that can result in patients “experience[ing] prolonged pain and suffering unnecessarily.”¹¹⁹ Long wait times lead to patient dissatisfaction, and in some cases patients leave the ED without receiving any care.¹²⁰ “Patients who [leave] the ED without being seen [are] twice as likely to report worsened health problems.”¹²¹ ED overcrowding also results in increased time on ambulance diversion—hospitals divert ambulances to other EDs because their ED is at or over capacity—which increases transport times and delays care.¹²² In March 2010, 22% of all hospitals and 45% of urban hospitals reported spending time on ambulance diversion within the previous twelve months.¹²³

Before solutions to the unintended consequences of EMTALA can be considered, a more detailed examination of the statute is required in order to better understand what its intended consequences were.

year. These associations suggest that not only do many patients know about the law, but also that such awareness may lead to increased ED use. . . . The most important policy implication of our observed association between EMTALA awareness and increased ED use may be the possibility of reducing ED crowding by modifying or eliminating EMTALA.”).

117. See Derlet & Richards, *supra* note 103, at 66–67.

118. Hoot & Aronsky, *supra* note 107, at 130 (reporting multiple studies finding increased patient mortality rates associated with ED overcrowding); see Derlet & Richards, *supra* note 103, at 66 (“Poor outcome has resulted from overcrowded conditions at some hospitals. For example, . . . a patient sat in the hallway for nearly 8 hours with an enlarging subdural hematoma because the ED staff, stretched past its limit, was too busy to evaluate him. . . . Feeling rushed and under time pressure results in errors, risk of poor outcome, and risk of malpractice or legal action.”).

119. Derlet & Richards, *supra* note 103, at 66; see Hoot & Aronsky, *supra* note 107, at 130–31 (reporting studies finding treatment delays associated with ED overcrowding).

120. Derlet & Richards, *supra* note 103, at 66; Hoot & Aronsky, *supra* note 107, at 131.

121. Hoot & Aronsky, *supra* note 107, at 131.

122. Derlet & Richards, *supra* note 103, at 66; Hoot & Aronsky, *supra* note 107, at 130–31.

123. TRENDWATCH CHARTBOOK, *supra* note 22, at 33. Twenty-seven percent of hospitals reported ED overcrowding as the number one factor contributing to ambulance diversion. *Id.* at 34. Forty-two percent of hospitals reported a lack of staffed critical care beds as the number one factor contributing to ambulance diversion. *Id.*

III. EXAMINING EMTALA

A. Congress's Intent in Enacting EMTALA

Congress passed EMTALA in direct response to the nation's problem of patient dumping¹²⁴ as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.¹²⁵ Patient dumping is when a hospital refuses a person emergency medical care due to the person's uninsured status or inability to pay.¹²⁶ Some cases of patient dumping included the patient being transferred to another hospital, typically a public hospital, without first being sufficiently stabilized; in other words, the patient who was unable to pay for medical care was dumped on another hospital.¹²⁷ Patient dumping was a practice that received a great deal of attention from the press and occurred at hospitals nationwide.¹²⁸

The House Committee on Ways and Means (HCWM) explained the purpose of EMTALA quite clearly:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred

124. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended in 42 U.S.C. § 1395dd (2012)); H.R. REP. NO. 99-241, pt. 1, at 27 (1985).

125. Pub. L. No. 99-272, 100 Stat. 82 (codified as amended in scattered sections of the U.S. Code).

126. Elizabeth A. Larson, Note, *Did Congress Intend to Give Patients the Right to Demand and Receive Inappropriate Medical Treatments?: EMTALA Reexamined in Light of Baby K*, 1995 WIS. L. REV. 1425, 1425; Bera, *supra* note 20, at 617; Treiger, *supra* note 1, at 1186–87.

127. W. Adam Malizio, Note, *Moses v. Providence Hospital: The Sixth Circuit Dumps the Federal Regulations of the Patient Anti-Dumping Statute*, 27 J. CONTEMP. HEALTH L. & POL'Y 213, 214 (2010). Patients would be transferred to public hospitals because public hospitals were required by the Hill-Burton Act to provide some medical services to “persons unable to pay.” See 42 U.S.C. § 291c(e) (2012); 42 C.F.R. § 53.111 (2014).

128. See, e.g., Edward Iwata, *East Bay Hospitals: Patient-Dumping Charges Probed*, S.F. CHRONICLE, Dec. 18, 1985, at 6; Robert Pear, *Tax for Medicare Rejected in House*, N.Y. TIMES, July 24, 1985, at A13; Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES, May 25, 1986, at E4; Howard Wolinsky, *Fivefold Rise in 'Patient Dumping' Found*, CHI. SUN TIMES, Mar. 20, 1987, at 24.

improperly, sometimes without the consent of the receiving hospital.¹²⁹

The HCWM is very clearly referring to patient dumping in its comments. The HCWM went on to acknowledge that the then-recent change to the PPS may have increased the instances of patient dumping.¹³⁰ In passing EMTALA, the HCWM wanted “to provide a strong assurance that pressures for greater hospital efficiency [were] not to be construed as license to ignore traditional community responsibilities and loosen historic standards.”¹³¹ The traditional responsibilities and historic standards referred to by the HCWM were hospitals’ traditional role of providing care to the poor.¹³² In other words, EMTALA was Congress’s attempt to ensure that uninsured patients with emergency medical needs would still be cared for by hospitals despite the pressures placed on hospitals by the PPS to do otherwise.

The direct connection between EMTALA’s enactment and uninsured patients in need of emergency care is further illustrated by the House Judiciary Committee’s commentary: “In recent years there has been a growing concern about the provision of adequate emergency room services to individuals who seek care, particularly as to the indigent and uninsured.”¹³³ Just like the HCWM, the House Judiciary Committee’s comments regarding EMTALA clearly refer to the act of patient dumping and its members concerns over patient dumping.

The views expressed by the HCWM and the House Judiciary Committee that EMTALA was a direct response to patient dumping are further supported by comments made by California Representative Fortney Stark, a sponsor of the Act.¹³⁴ Representative Stark began his floor statement by describing the problem of patient dumping facing the nation.¹³⁵ Next, he recounted two cases of patient dumping in great detail, which he thought would not have occurred if the patients were

129. H.R. REP. NO. 99-241, pt. 1, at 27 (1985).

130. *Id.*; see also *supra* notes 52–59 and accompanying text (detailing the PPS).

131. H.R. REP. NO. 99-241, pt. 1, at 27.

132. See Welzien, *supra* note 1, at 21–22.

133. H.R. REP. NO. 99-241, pt. 3, at 5.

134. 131 CONG. REC. 35,813 (1985) (statement of Rep. Fortney H. Stark).

135. *Id.* (“Mr. Speaker, an estimated 200,000 patients are refused care at hospital emergency rooms each year because they cannot afford to pay. This is known as ‘dumping,’ which is the practice of transferring medically unstable indigent patients from private hospitals to local public hospitals. It is a growing problem with tragic results.”)

insured.¹³⁶ Throughout his entire floor statement, the only purpose that Representative Stark stated for enacting EMTALA was “to prevent this kind of dumping of indigent patients.”¹³⁷

Members of the Senate also understood EMTALA to be a direct response to patient dumping that was solely concerned with the emergency care of uninsured patients. For example, when speaking about the Senate version of EMTALA, Utah Senator Orrin Hatch stated,

The intent of this bill is honorable, that is to address concerns about inadequate health care for our citizens who do not have health insurance or who are “underinsured” There have been disturbing reports about hospitals referring, and in some instances refusing to treat patients who present themselves for care, but who don’t have health insurance. Others apparently require a substantial cash deposit from uninsured patients before admitting the individual for care.¹³⁸

Minnesota Senator David Durenberger was also very clear about his understanding of EMTALA’s purpose when he addressed the Senate. After mentioning two recent news stories about patient dumping, he stated:

[T]he practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable. . . . All Americans, rich or poor, deserve access to quality health care. . . . The purpose of this amendment is to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.¹³⁹

Senators Kennedy, Dole, Heinz, and Proxmire all made statements similar to Senator Durenberger’s statement, each explaining the need for EMTALA in terms of stopping patient dumping specifically.¹⁴⁰

136. *Id.* at 35,814. (“Clearly, if these patients had been middle class with health insurance they never would have faced the horrors that they encountered.”)

137. *Id.*

138. Larson, *supra* note 126, at 1430–31 (alteration in original) (quoting S. REP. NO. 99-146, at 460–61 (1985)).

139. 131 CONG. REC. 28,568 (1985) (statement of Sen. Durenberger).

140. *Id.* at 28,569 (statements of Sen. Kennedy, Sen. Dole, Sen. Heinz, and Sen. Proxmire).

Given how clearly the legislators drew the connection between EMTALA's enactment and their desire to stop patient dumping specifically, the language of the statute is rather surprising. To better understand why the courts would be confused by the inconsistency between the Legislature's clear intent and the statutes' text, the statute itself must be examined.

B. EMTALA: Statute and Regulations

EMTALA applies to EDs within hospitals that are Medicare participants.¹⁴¹ A hospital's duties under EMTALA are triggered when "any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition."¹⁴² The individual does not have to be a Medicare participant or Medicare eligible, even though the statute only applies to hospitals participating in the Medicare program.¹⁴³

Once the request for an examination or treatment is made, the medical screening portion of EMTALA is triggered.¹⁴⁴ "[T]he hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists."¹⁴⁵ While the statute defines an "emergency medical condition," it does not define an "appropriate medical screening."¹⁴⁶ The medical screening examination is not judged by a national standard; rather, a hospital is only required to perform a medical screening "within the capability" of its own ED, and the screening must lead to "reasonable clinical confidence" as to whether an emergency medical condition exists.¹⁴⁷

If it is determined through the medical screening examination that the individual has an emergency medical condition, then the hospital

141. 42 U.S.C. § 1395dd(a), (e)(2) (2012); 42 C.F.R. § 413.65(a)(2) (2014) (defining provider based status).

142. 42 U.S.C. § 1395dd(a).

143. *Id.* § 1395dd(a), (e)(2); Lee, *supra* note 81, at 151.

144. *See* 42 U.S.C. § 1395dd(a).

145. *Id.*

146. *Id.* § 1395dd(e).

147. *See id.* § 1395dd(a); 1 HEALTH LAW PRACTICE GUIDE § 14:28 (2014) ("A MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. . . . The MSE must be appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital."); Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 656 (2007).

must “stabilize the medical condition,” or transfer the individual to a different medical facility.¹⁴⁸ Even when a hospital is going to transfer an individual with an emergency medical condition, it is typically required to stabilize the individual first.¹⁴⁹ An individual is “stabilized” when “no material deterioration of the [emergency medical] condition is likely . . . to result from or occur during the transfer of an individual.”¹⁵⁰ “Transfer” within the context of EMTALA includes discharging an individual.¹⁵¹

The statute imposes civil monetary penalties on hospitals and physicians for violations and provides individuals harmed by a violation of the Act a private cause of action.¹⁵²

Indicative of its intended purpose to stop patient dumping, in one of the clearest sections of the statute, § 1395dd(h) expressly disallows any delay in either the required medical screening examination or stabilization “in order to inquire about the individual’s method of payment or insurance status.”¹⁵³ Beyond this language though, the statute does not contain any mention of uninsured or indigent persons, patient dumping, economic discrimination, or insurance status—all the terms you would expect a statute with the specific purpose of stopping patient dumping to have. Given how prevalent the problem of patient dumping was in the news¹⁵⁴ and how clear the connection between EMTALA and patient dumping was in the minds of the legislators,¹⁵⁵ the legislators might not have imagined that EMTALA could be interpreted to mean anything other than to stop patient dumping. Perhaps the legislators thought that the prohibition in § 1395dd(h) was

148. 42 U.S.C. § 1395dd(b).

149. *Id.* § 1395dd(c).

150. *Id.* § 1395dd(e)(3)(B).

151. *Id.* § 1395dd(e)(4). The statute defines “transfer” as

the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

Id.

152. *Id.* § 1395dd(d); *see supra* Part II.A.3.

153. 42 U.S.C. § 1395dd(h).

154. *See, e.g.,* Dudley Clendinen, *Meeting on Poor and Health Care: Growing Number of Uninsured Putting a Financial Strain on University Hospitals*, N.Y. TIMES, Oct. 9, 1985, at B13; Reinhold, *supra* note 128.

155. *See supra* notes 129–40 and accompanying text.

enough to stop the problem—possibly rationalizing that if the hospital could not ask about a patient’s ability to pay, then it could not discriminate against them on that basis. Unfortunately, the lack of clear, overt language limiting EMTALA to genuine instances of patient dumping led the courts to interpret EMTALA in conflicting ways.

IV. CLARIFYING THE STATUTE:
JUDICIAL INTERPRETATION OF EMTALA

A. *District Courts Divided*

Even though (a) the Senators and Representatives were very clear when debating EMTALA that it was intended as a direct response to patient dumping,¹⁵⁶ (b) the general public understood it to be an anti-patient-dumping law after its enactment,¹⁵⁷ and (c) various members of the U.S. government had the same understanding,¹⁵⁸ the statute’s language is not so clear.¹⁵⁹ Following EMTALA’s passage, the courts have struggled to clarify and interpret the requirements of the statute, especially the medical screening requirement.¹⁶⁰

In *Nichols v. Estabrook*,¹⁶¹ one of the earliest EMTALA cases, the parents of a deceased sixteen-week-old attempted to establish the ED physician’s liability based on a duty of care allegedly created by

156. See *supra* Part III.A.

157. See, e.g., Katherine Bishop, *Hospital May Lose Funds Over Transfers of Poor*, N.Y. TIMES, Apr. 1, 1987, at A17; John Gorman, *Hospital Is Accused of ‘Dumping’ Patient*, CHI. TRIB., Aug. 5, 1988, at D1; Martin Tolchin, *U.S. Seeks to Require Treatment of All Hospital Emergency Cases*, N.Y. TIMES, June 18, 1988, at 1; *Hospital Charged with Dumping Homeless Patient*, N.Y. TIMES, Nov. 17, 2006, at A29; *Hospitals’ Handling of Uninsured Patients Faulted*, N.Y. TIMES, Mar. 30, 1988, at A25.

158. See Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, 73 Fed. Reg. 48,434, 48,654 (Aug. 19, 2008) (codified at 42 C.F.R. pt. 489) (“The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. . . . Congress incorporated these antidumping provisions . . . to ensure that individuals with emergency medical conditions are not denied essential lifesaving services.”); Tolchin, *supra* note 157 (“‘Clearly our objectives are to prevent patient dumping, and to stop it when it does occur,’ three officials of the Department of Health and Human Services said in a letter to hospital administrators accompanying the proposed new regulations . . .”).

159. See 42 U.S.C. § 1395dd (2012); Lee, *supra* note 81, at 153.

160. Cohen, *supra* note 147, at 659–60 (“In the twenty years since EMTALA’s enactment, the screening requirement has engendered more confusion than any other EMTALA provision.”).

161. 741 F. Supp. 325 (D.N.H. 1989).

EMTALA.¹⁶² In that case, the parents brought their baby into the ED complaining of flu symptoms.¹⁶³ The ED physician examined the baby, ordered and interpreted blood tests, contacted the family's pediatrician, and recommended that the parents take the baby to a nearby hospital where the pediatrician would be waiting for them.¹⁶⁴ When the parents requested an ambulance, the ED physician responded that the ambulance would only be used in an emergency, their situation was not an emergency, and the baby would be fine.¹⁶⁵ When the parents arrived at the other hospital fifteen minutes later the baby showed diminished vital signs and eventually died forty-five minutes later.¹⁶⁶ The court interpreted the legislative history of EMTALA and held that the parents failed to state a cause of action under EMTALA because they did "not allege that their financial condition or lack of health insurance contributed to Dr. Estabrook's decision not to treat their son."¹⁶⁷ The district court reasoned that Congress intended EMTALA "to provide some assurance that patients with emergency medical conditions will be examined and treated regardless of their financial resources," and because the interest Congress sought to protect with the Act was not violated there could be no cause of action.¹⁶⁸

The groundwork having been laid in *Nichols* for limiting EMTALA to cases of genuine patient dumping,¹⁶⁹ the courts began to build on the *Nichols* court's reasoning. In *Evitt v. University Heights Hospital*,¹⁷⁰ the court granted summary judgment for the hospital because the plaintiff was "unable to present evidence which could prove that she was turned away from the Hospital for economic reasons, in violation of [EMTALA]."¹⁷¹ In that case, the plaintiff arrived at the ED complaining of chest pains.¹⁷² A doctor examined her, determined that she did not have an emergency medical condition, and discharged her to

162. *Id.* at 326, 329.

163. *Id.* at 326.

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.* at 330.

168. *Id.*

169. *See id.*

170. 727 F. Supp. 495 (S.D. Ind. 1989).

171. *Id.* at 498.

172. *Id.* at 496.

her home.¹⁷³ The plaintiff returned to the ED later that day and was admitted to critical care for a recent heart attack.¹⁷⁴ The plaintiff argued that the hospital violated the appropriate medical screening requirement of EMTALA when the doctor failed to use a “12-lead EKG test” when examining her.¹⁷⁵ The district court disagreed with the plaintiff’s argument because it “reache[d] beyond the purpose of the statute, which is specifically directed toward preventing prospective patients from being turned away for economic reasons.”¹⁷⁶ The court went on to state that the plaintiff’s argument focused on the doctor’s initial diagnosis “rather than focusing on the ‘dumping’ problem.”¹⁷⁷ The court clarified that “[c]laims regarding diagnosis and treatment lie in the area of medical malpractice, an area traditionally regulated by state law. To adjudicate these issues under the anti-dumping provision would lead to federal preemption not contemplated under this Act.”¹⁷⁸ The court reasoned,

Taking the plaintiff’s argument to its logical conclusion would lead to the result that any patient dissatisfied with an emergency room diagnosis and release could sue the hospital under the anti-dumping provision. This construction would, in effect, make the Hospital the guarantor of the physicians’ diagnosis and treatment irrespective of how reasonable such diagnosis may have appeared at the time of the patient’s release, and irrespective of whether the patient was released for lack of funds or similar ulterior motive, on the one hand, or whether she was released simply because the physician after a reasonable examination saw no reason to commit her for hospitalization. We do not believe that the federal statute goes so far.¹⁷⁹

By limiting EMTALA’s application to instances of economic discrimination in accordance with the statute’s purpose, the *Evitt* court avoided improperly making EMTALA a federal malpractice statute. The required showing of economic discrimination helps to draw the line

173. *Id.*

174. *Id.*

175. *Id.* at 497.

176. *Id.* (citing *Reid v. Indianapolis Osteopathic Med. Hosp., Inc.*, 709 F. Supp. 853, 853 (S.D. Ind. 1989)).

177. *Id.*

178. *Id.*

179. *Id.* at 497–98.

between an EMTALA violation and medical malpractice, without which the line between the two becomes very blurry.¹⁸⁰

The *Evitt* court's fear of EMTALA becoming confused with standard medical malpractice claims was shared by the court in *Stewart v. Myrick*.¹⁸¹ In *Stewart* the court granted summary judgment to the hospital in a wrongful death action because the case was not an act of patient dumping, which would require the plaintiff to have been refused "medical care for economic reasons."¹⁸² In that case the decedent had gone to the ED twice prior to his death.¹⁸³ There were some genuine issues of fact as to the diagnosis and treatment of the decedent; however, it was undisputed that the decedent was neither discharged nor denied care due to economic reasons.¹⁸⁴ The court reasoned that the plaintiff's case was a standard medical malpractice claim that did "not present the type of evil that Congress sought to eliminate in the Act," and therefore the claim was dismissed.¹⁸⁵

After *Nichols*, *Evitt*, and *Stewart*, it seemed that the district courts were in agreement that EMTALA's legislative history clearly showed that EMTALA was intended to stop genuine instances of patient dumping, and applying the statute without a showing of economic discrimination would come too close to crossing into the prohibited realm of medical malpractice. This approach to interpreting EMTALA took a different direction with *Deberry v. Sherman Hospital Ass'n*.¹⁸⁶

In *Deberry* the court changed the course of judicial interpretation in EMTALA litigation by denying the defendant hospital's summary judgment motion even though the plaintiff did not allege that the hospital failed to stabilize her daughter for economic reasons.¹⁸⁷ In this

180. See generally Cohen, *supra* note 147 (examining EMTALA's screening requirement and suggesting ways to distinguish EMTALA screening violation claims from state medical malpractice claims); Lee, *supra* note 81, at 168 (noting the common complaint that the plaintiffs' bar use EMTALA to remove state medical malpractice claims to federal court); Larson, *supra* note 126, at 1457-58 (discussing the confusion between medical malpractice claims and EMTALA claims, and arguing for the courts to require a showing of economic discrimination for EMTALA claims in order to avoid this confusion).

181. See *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990); *Evitt*, 727 F. Supp. at 497-98.

182. *Stewart*, 731 F. Supp. at 436.

183. *Id.* at 434.

184. *Id.*

185. *Id.* at 436.

186. 741 F. Supp. 1302 (N.D. Ill. 1990).

187. *Id.* at 1305-07 ("Sherman argues that, in order to state a cause of action under § 1395dd, a plaintiff must allege facts which support the conclusion that he was "dumped" . . .

case the plaintiff's daughter was brought into the ED with multiple symptoms, was treated, and then discharged.¹⁸⁸ Two days later the daughter was admitted to the hospital with spinal meningitis.¹⁸⁹ The plaintiff alleged that the hospital violated the stabilization prong of EMTALA.¹⁹⁰ Relying on *Evitt* and *Stewart*, the hospital brought a summary judgment motion for failure to state a claim because this was not a case of patient dumping.¹⁹¹ The court agreed that Congress enacted EMTALA "to alleviate the problem of 'patient dumping'"; however, unlike the courts in *Evitt* and *Stewart*, the *Deberry* court declined "to depart from the plain meaning of the statute as enacted."¹⁹² In applying EMTALA the court reasoned that the Act "nowhere mentions either indigency, an inability to pay, or the hospital's motive as a prerequisite to statutory coverage," therefore, the Act is not limited to instances of patient dumping even though the legislative history indicates otherwise.¹⁹³ The court stated that the plain meaning of statutory language must be followed, and if one of the statute's terms is ambiguous, then legislative history may be used to help interpret the term.¹⁹⁴ The court held that a failure to stabilize claim under EMTALA did not require the showing of an economic motive.¹⁹⁵ Subsequent courts found the *Deberry* court's reasoning to be persuasive and declined to require a showing of economic discrimination in EMTALA claims;¹⁹⁶ however, the Sixth Circuit applies the *Deberry* court's reasoning in a unique fashion.

from a hospital emergency room based upon his inability to pay. . . . Plaintiff Deberry has alleged no such facts and has in fact admitted to her daughter's having received at least *some* treatment. . . . [¶] For the foregoing reasons, Sherman's motion to dismiss Count I is denied.").

188. *Id.* at 1303.

189. *Id.*

190. *Id.*

191. *Id.* at 1303, 1305–06.

192. *Id.* at 1304, 1306.

193. *Id.* at 1306.

194. *Id.*

195. *See id.* at 1306–07.

196. *See, e.g., Brodersen v. Sioux Valley Mem'l Hosp.*, 902 F. Supp. 931, 947 (N.D. Iowa 1995) (relying on the reasoning in *Deberry*).

B. The Sixth Circuit's Approach: An Improper Motive Requirement

In *Cleland v. Bronson Health Care Group, Inc.*,¹⁹⁷ the Sixth Circuit affirmed the district court's dismissal of the complaint on different grounds,¹⁹⁸ and in so doing distinguished itself amongst the federal appellate courts. In *Cleland* the plaintiff's fifteen-year-old son was examined by a physician in the defendant's ED, diagnosed with influenza, and discharged in the early morning.¹⁹⁹ Sadly, the diagnosis was incorrect, and the son returned to the hospital later that night, suffering from a heart attack, and died.²⁰⁰ The plaintiff brought suit for violations of both the appropriate medical screening and stabilization prongs of EMTALA.²⁰¹

The Sixth Circuit declined to follow the reasoning of the district court, which relied upon the legislative history of EMTALA to limit EMTALA claims to indigent or uninsured patients.²⁰² Instead the Sixth Circuit followed the reasoning of the *Deberry* court, which relied upon the text of EMTALA to allow claims by patients not alleging that ability to pay was the reason they were denied treatment.²⁰³ In discussing canons of construction, the Sixth Circuit recognized that the plain meaning interpretation of the words in EMTALA "leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of."²⁰⁴ The court explicitly declined to correct the statute through its ability to interpret the statute and stated that it was up to Congress to correct its mistake.²⁰⁵ Accordingly, the court reasoned that the plain words of EMTALA made clear that "[t]he benefits and rights of the statutes extend 'to any individual' who arrives at the hospital."²⁰⁶

197. 917 F.2d 266 (6th Cir. 1990).

198. *Id.* at 268 ("The district court . . . dismissed the complaint under Rule 12(b)(6), Federal Rules of Civil Procedure, based on its interpretation that the Act applied only to indigent and uninsured patients. We affirm the district court, though on different grounds.").

199. *Id.* at 268.

200. *Id.*

201. *Id.* at 269. These alleged EMTALA violations were in addition to the plaintiffs' state medical malpractice action. *Id.* at 268.

202. *Id.*

203. *Id.* at 270.

204. *Id.*

205. *See id.* at 270 ("[I]t is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress.").

206. *Id.* at 269.

Although the Sixth Circuit held that the plain words of a statute were controlling, the court also held that legislative history could be used to interpret ambiguous phrases, such as *appropriate* medical screening.²⁰⁷ Considering the circumstances in which EMTALA was enacted and the legislature's intent to stop patient dumping, the court reasoned "'appropriate' can be taken to mean care similar to care that would have been provided to any other patient."²⁰⁸ The court further reasoned that "appropriate" must refer to the hospital's motives.²⁰⁹ This interpretation of 'appropriate' screening is commonly referred to as the Sixth Circuit's improper motive requirement.

The Sixth Circuit provided further clarification of its improper motive requirement. The Sixth Circuit's test of whether or not a hospital violated its obligation of providing an appropriate medical screening under EMTALA is a two part test. First, the court must determine whether the hospital "act[ed] in the same manner as it would have for the usual paying patient," if so, then the screening was appropriate and the court does not consider the second part of the test.²¹⁰ If the hospital provides a disparate screening, then the court must apply the second part of the test: the court must determine whether the hospital provided a disparate screening because of the patient's sex, race, ethnic group, occupation, politics, personal prejudice, condition (e.g., drunkenness, AIDS), or inability to pay,²¹¹ and if so, the hospital is in violation of the medical screening prong of EMTALA.²¹²

207. *Id.* at 271 ("Congress did limit the cause of action provided by the Act to only those who did not receive an 'appropriate' screening In attempting to interpret [this] ambiguous phrase[], we can look to legislative history, along with other aids to construction."). The court referred to 'appropriate' as "one of the most wonderful weasel words in the dictionary." *Id.*

208. *Id.*

209. *Id.* at 272 ("[T]he terms of [EMTALA], specifically referring to a medical screening exam by a hospital 'within its capabilities' precludes resort to a malpractice or other objective standard of care as the meaning of the term 'appropriate.' Instead, 'appropriate' must more correctly be interpreted to refer to the motives with which the hospital acts.")

210. *See id.*

211. *See id.* This is not an exhaustive list of reasons that can be considered an improper motive for providing a less than standard screening or denying a medical screening entirely. *See id.*

212. *See id.* Some courts have applied the disparate screening portion from the first part of the Sixth Circuit's improper motive requirement, but instead of applying the second part of the test by determining the hospital's motive behind the disparate screening, they merely determine whether or not the screening comported to the hospital's standard screening procedures. Kim C. Stanger, *Private Lawsuits Under EMTALA*, HEALTH LAW., June 2000, 27, at 29 (2000).

Applying this improper motive requirement in *Cleland*, the Sixth Circuit held “that the complaint simply fail[ed] to allege any inappropriateness in the medical screening in the sense required by [EMTALA].”²¹³ The court reasoned that the outcome would not have been different for a patient with different characteristics.²¹⁴ In other words, the plaintiffs did not allege any facts that the screening given to their son would have been different if he had a different financial status (or race, occupation, etc.); therefore, there was no violation of EMTALA’s screening prong. In a later case, the Sixth Circuit applied its improper motive requirement to the stabilization prong of EMTALA and this led to the first and only Supreme Court decision interpreting EMTALA.

C. The Supreme Court Interprets EMTALA

A little over a decade after EMTALA’s enactment, the Supreme Court granted certiorari to its first EMTALA case, *Roberts v. Galen of Virginia, Inc.*²¹⁵ In *Roberts* the Court, in a rather brief opinion, reversed the Sixth Circuit’s decision affirming the district court’s summary judgment in favor of the defendant hospital.²¹⁶ The Sixth Circuit, in its holding, had applied the improper motive requirement articulated in *Cleland* to the stabilization prong of EMTALA.²¹⁷ In reversing the Sixth Circuit, the Court reasoned that the word *appropriate* was not included in § 1395dd(b) of EMTALA—the stabilization prong—and therefore claims brought *under that section* did not require the showing of an improper motive.²¹⁸

The Court limited its opinion to only EMTALA’s stabilization prong by “hold[ing] that § 1395dd(b) contains no express or implied ‘improper motive’ requirement.”²¹⁹ The Court was explicitly clear that it was not considering whether a showing of an improper motive was required for

213. *Cleland*, 917 F.2d at 271.

214. *Id.*

215. 525 U.S. 249 (1999) (per curiam).

216. *Id.* at 254.

217. *Id.* at 252 (“The Court of Appeals’ holding—that proof of improper motive was necessary for recovery under § 1395dd(b)’s stabilization requirement—extended earlier Circuit precedent deciding that the ‘appropriate medical screening’ duty under § 1395dd(a) also required proof of an improper motive.”).

218. *Id.* at 253 (“But there is no question that the text of § 1395dd(b) does not require an ‘appropriate’ stabilization, nor can it reasonably be read to require an improper motive.”).

219. *Id.*

claims under the medical screening prong of EMTALA when it stated in dicta, “[t]he question of the correctness of the *Cleland* court’s reading of § 1395dd(a)’s ‘appropriate medical screening’ requirement is not before us, and we express no opinion on it here.”²²⁰ In light of the only Supreme Court decision to date pertaining to EMTALA,²²¹ the Sixth Circuit’s improper motive requirement remains good law as to EMTALA’s appropriate medical screening requirement. The fact that the Sixth Circuit’s attempt to bring its decisions more in line with the legislative history of EMTALA remains good law gives hope to the idea that other solutions can be found to further resolve the inconsistencies between the Act’s intended purpose and its practical effects.

V. SUGGESTED SOLUTIONS FOR THE UNINTENDED CONSEQUENCES OF EMTALA

A. Congress Should Amend EMTALA

One way to resolve the inconsistencies between the Legislature’s intended purpose for EMTALA and the Act’s text is for Congress to correct its mistake and amend EMTALA.²²² This Comment suggests a series of amendments to EMTALA that will bring the Act into conformity with its legislative history and simultaneously alleviate some of the burden the Act places on EDs.

Congress should amend EMTALA in order to limit the Act’s requirements to those individuals who the Legislature intended to protect when it promulgated the Act. To amend EMTALA in the most efficient way possible and simultaneously clarify ambiguous text, § 1395dd(e) should be amended to read as follows (suggested changes in italics):

(e) Definitions

In this section:

(1) *The term “individual” means a person who is either indigent or uninsured.*²²³

220. *Id.*

221. As of the time of this Comment’s publication, *Roberts* is the only Supreme Court decision pertaining to EMTALA.

222. See *supra* notes 204–05 and accompanying text.

223. Other commentators have suggested using *indigent and uninsured individual* rather than *indigent or uninsured individual* in proposing an amendment to EMTALA. See Smith, *supra* note 11, at 1534 n.196. This Comment however, suggests using an inclusive *or* rather than using a conjunction such as *and* so that the amended version of EMTALA will be

- (2)²²⁴ The term “emergency medical condition” means—
- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected 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; or
 - (B) with respect to a pregnant woman who is having contractions—
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- (3) The term “participating hospital” means a hospital that has entered into a provider agreement under section 1395cc of this title.
- (4) *The term “appropriate medical screening” means a screening consistent with the hospital’s standard procedure provided to patients with the ability to pay for their emergency medical care.*
- (5) (A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (2)(A), to provide such medical treatment of the

consistent with the Act’s legislative history as much as possible. Members of both the House and Senate spoke in terms of both insurance and indigent status when referring to the ills that EMTALA was meant to address. *See, e.g.*, 131 CONG. REC. 28,568 (1985) (statement of Sen. Durenberger) (“[The] practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable. . . . Congress and the State legislatures are groping for areas to get quality health care to the uninsured Americans.”); H.R. REP. NO. 99-241, pt. 3, at 5 (1985) (“In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured.”). Using an inclusive *or* in *indigent or uninsured* ensures that persons of either status are protected under EMTALA, as the Legislature intended, whereas using *indigent and uninsured* might be interpreted to exclude individuals not meeting both criteria. The essence of patient dumping is the hospital’s motivation not to be stuck with the cost of care for those individuals it perceives will be unable to pay; therefore, it is most appropriate for EMTALA to protect those individuals most likely to be affected by the hospital’s motivation—indigent individuals and uninsured individuals.

224. This Comment suggests amending EMTALA to include two additional definitions; therefore, the enumeration of this statutory section must be altered as reflected here.

condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (2)(B), to deliver (including the placenta).

(B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (2)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (2)(B), that the woman has delivered (including the placenta).

(6) The term “transfer” means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(7) The term “hospital” includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).²²⁵

Other commentators have suggested that EMTALA’s nondiscrimination section should be amended “to explicitly state that the Act is intended only to redress economic discrimination.”²²⁶ One suggestion that is in harmony with the other solutions offered by this Comment, and therefore should be adopted, suggests amending § 1395dd(g) to read as follows:

(g) Nondiscrimination.

(1) Intent.

This Act is intended to redress only economic discrimination against individuals with emergency medical conditions by participating hospitals. Any noneconomic discrimination against individuals with emergency medical

225. See 42 U.S.C. § 1395dd(e) (2012). Italics are only used to denote the changes to the statutory text resulting from this Comment’s suggested amendments.

226. Smith, *supra* note 11, at 1537.

conditions is governed by 42 U.S.C. § 1983; Title VI of the Civil Rights Act of 1964; The Rehabilitation Act, 29 U.S.C. § 701; The Americans with Disabilities Act, 42 U.S.C. § 12101; and the Child Abuse Amendments of 1984, 42 U.S.C. § 5101.

(2) Acceptance of appropriate transfers.

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an indigent and uninsured individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.²²⁷

These suggested amendments more accurately express the intention of the Legislature when it promulgated EMTALA than the current language of the statute. As the courts have noted, the current language of the statute “leads to . . . result[s] considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of.”²²⁸ These amendments fix Congress’s mistake by limiting EMTALA to actual instances of patient dumping.

Defining *individual* in the proposed manner²²⁹ limits EMTALA’s protection to indigent or uninsured persons—those persons the Legislature intended to protect with the Act.²³⁰ Defining *individual* resolves any confusion as to EMTALA’s proper application by providing plain language for the courts to follow.²³¹ To state a cause of action under the amended statute, a plaintiff must prove that she was

227. *Id.* This note’s proposed language for an amended nondiscrimination section of EMTALA is well written and combines with this Comment’s other proposed amendments to clearly state that EMTALA only applies to situations of economic discrimination by hospitals towards indigent or uninsured persons.

228. *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 270 (6th Cir. 1990).

229. *See supra* note 223 and accompanying text.

230. *See supra* Part III.A.

231. *See Smith, supra* note 11, at 1534 (“The confusion over EMTALA’s application centers around the Act’s application to ‘any individual.’”). Adding a definition for “individual” is an efficient way to clarify who EMTALA applies to, although the same end could be achieved by several amendments adding “indigent or uninsured” before each instance of “individual” throughout the Act. *See id.* at 1534–36 (proposing amendments to EMTALA adding “indigent and uninsured” before occurrences of “individual.”).

either indigent or uninsured when she arrived at the ED, which does not seem to be an overly burdensome task.

While defining *individual* clarifies who EMTALA covers, defining *appropriate medical screening* clarifies what actions EMTALA requires. The amendment formally adopts the disparate screening definition from the first part of the Sixth Circuit's improper motive requirement that many courts already apply.²³² Under the amended statute, a plaintiff would need to prove that the hospital did not follow the same screening procedures in the ED when screening her as the hospital follows when screening an insured patient.

An additional benefit to defining *appropriate medical screening* with plain language text is that the ambiguity of the phrase is removed. The clarity provided by the definition should resolve the split between the federal appellate courts and subsequently lead to greater consistency in judicial decisions. Furthermore, the removal of this ambiguity will assist hospitals in developing better practices. Hospitals wishing to comply with EMTALA will now know that they need to develop standard procedures for screening patients in the ED and follow those procedures with every patient, or else have a nondiscriminatory reason for deviating from the procedure.²³³

While defining *appropriate medical screening* clarifies what actions EMTALA requires, the amendment to § 1395dd(g) clarifies what motives the hospital must have if disparate treatment is given. As discussed previously, the Legislature clearly intended for EMTALA to prohibit EDs from refusing emergency medical care to indigent or uninsured persons because of the patient's inability to pay for the care.²³⁴ The amended nondiscrimination section limits EMTALA

232. See *supra* notes 210–12 and accompanying text.

233. This does not mean that hospitals should engage in patient dumping and have a prepared noneconomic reason for providing disparate treatment; rather, this is merely an attempt to account for situations where a deviation from standard procedures is both necessary and proper. An example of such a situation would be when a patient arrives at a small, rural ED with a broken leg and a medical screening begins in accordance with standard procedures, but before the examination is complete, a gunshot victim arrives and the medical care provider deviates from the standard procedure by stepping away from the patient with the broken leg to assist with the gunshot victim. It would behoove those persons in charge of developing a hospital's standard procedures to incorporate situations such as this hypothetical situation into their formal standard procedures; however, every situation is not foreseeable, and some procedure developers might overlook certain situations. Those hospitals attempting in good faith to comply with EMTALA should not be penalized for their lack of foresight.

234. See *supra* Part III.A.

protection to the economic discrimination that the legislators found abhorrent.²³⁵ The courts agree in dicta to this understanding of the legislative history but disagree over the role legislative history plays in applying the statute.²³⁶ This amendment resolves the disagreement by putting in plain language the intent of the Legislature and inserting it into the statute for the courts to apply. This amendment also incorporates the second part of the Sixth Circuit's improper motive requirement into the statute.²³⁷ Under the amended statute, a plaintiff would need to prove that the hospital provided a disparate medical screening because the hospital believed that the plaintiff would be unable to pay for her care.²³⁸

Adopting these amendments will also help to reduce some of the fiscal troubles hospitals with EDs currently face. By limiting EMTALA so that it only applies to indigent or uninsured persons, only those persons are granted a private cause of action under § 1395dd(d)(2) for injuries resulting from an EMTALA violation. The amendments reduce the pool of potential plaintiffs without granting the private cause of action to anyone not currently afforded that right. Additionally, the amendments require the plaintiff to prove three elements not currently required by the statute's language,²³⁹ which suggests fewer plaintiffs will bring claims because of an inability to prove the new elements. Therefore, it is reasonable to believe that adopting the proposed amendments will not increase the number of plaintiffs bringing claims under EMTALA. Hospitals will be able to save the money they are

235. See *supra* Part III.A.

236. See *supra* Part IV.A.

237. Cleland v. Bronson Health Care Grp., Inc., 917 F.2d 266, 271–72 (6th Cir. 1990).

238. Requiring plaintiffs to prove a hospital's motives or beliefs may be unduly burdensome, in which case Congress may wish to consider creating a rebuttable presumption of improper motive. See generally Cohen, *supra* note 147, at 680–88 (proposing the adoption of a three part disparate screening test which incorporates a rebuttable presumption of an improper motive); Stricker, *supra* note 12, at 1151–56 (outlining how a rebuttable presumption of improper motive might work).

239. Plaintiffs must prove (1) they are either indigent or uninsured, (2) the hospital either failed to provide any medical screening or the exam it did provide was not in accordance with the standard procedures the hospital follows when providing medical screening exams to insured patients, and (3) the reason the hospital provided a disparate screening was because it believed that the plaintiff was unable to pay for the care. It could be argued that plaintiffs currently have to prove element two because many courts use a disparate screening test to determine if a medical screening is an appropriate medical screening. See *supra* note 212. Even if element two is considered to be an element currently required to be proven, the other two new elements still add to the plaintiff's burden of proof.

currently spending on defending claims²⁴⁰ brought by persons who are neither indigent nor uninsured. Since there will be fewer claims brought against hospitals, it is reasonable to believe that there will be fewer judgments against hospitals as well. Fewer judgments against hospitals mean more savings.

Unfortunately, it is unlikely that hospitals spend billions of dollars in defending EMTALA claims each year; therefore, the cost savings from the proposed amendments alone will not balance out the billions of dollars in uncompensated care costs EMTALA creates. However, these savings might slow the rate of hospital and ED closures, which in turn could slow the rate of ED overcrowding. The money saved may allow hospitals that are closer to solvency (-1% or -2% profit margins) to remain open. Obviously, these savings will not have the same effect on hospitals facing -7% profit margins; thus, adoption of these amendments is not a complete solution to the fiscal problems burdening U.S. hospitals.

Although the suggested amendments limit EMTALA's application to indigent or uninsured persons, insured patients are not left without a remedy for denial of emergency medical care. Insured patients likely have other legal recourses available to them, which, depending on the jurisdiction, may include a medical malpractice claim.²⁴¹ Hospitals contract with private insurance companies and the government to provide services to patients covered under private or public insurance programs respectively.²⁴² The contract between the hospital and insurer creates a duty of care between the hospital and the patients covered by the insurance provider.²⁴³ If a hospital fails to provide the services required under those contracts to covered persons, the hospital will be

240. These costs include money spent on preparing for litigation (e.g., attorney's fees, expert witness fees), as well as the money spent for those claims that actually go to trial (e.g., attorney's fees, court costs, additional expert witness fees). The important point to understand is that hospitals lose some amount of money on every claim that is brought against them, regardless of whether the claim goes to trial.

241. *See, e.g.,* Hand v. Tavera, 864 S.W.2d 678, 678, 680 (Tex. App. 1993) (allowing a medical malpractice claim against the prepaid health plan ED physician for denying him admission to the hospital).

242. *See id.* at 679-80.

243. *See id.* at 680 (holding that "when a patient who has enrolled in a prepaid medical plan goes to a hospital emergency room and the plan's designated doctor is consulted, the physician-patient relationship exists and the doctor owes the patient a duty of care"); *see also* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 589 (7th ed. 2013) (discussing contractually created physicians' duty of care).

liable to the patient for breaching its contractually created duty of care. Additionally, it is to be expected that the care mandated by EMTALA will be used as a model for the most basic level of care negotiated for by private insurance companies. This is to be expected because the amendments do not remove EMTALA from Medicare's Conditions of Participation and the trend in American health care is for private insurance companies to adopt the standards set by the government.²⁴⁴

B. Courts Should Adopt the Sixth Circuit's Improper Motive Requirement

If the previously suggested amendments are not adopted, at the very least the federal courts of appeals should adopt the Sixth Circuit's improper motive requirement. Adoption of the improper motive requirement is a way for the courts to bring their decisions closer in line with the purpose of EMTALA while adhering to the accepted canons of construction.

As the *Cleland* court mentioned in dicta, it is likely that EMTALA is being applied in a broader manner than Congress intended because of the plain meaning of its text, but it is not for the courts to diverge from the plain meaning of statutory text.²⁴⁵ Adoption of the improper motive requirement preserves the text of EMTALA that has a plain meaning by continuing to apply EMTALA to all patients presenting at EDs requesting care. However, where there is ambiguity in text, such as "appropriate medical screening," courts have flexibility in interpreting that text. When determining ambiguous text's meaning, courts should consider the Legislature's purpose in enacting the statute.²⁴⁶ This method—applying the text's plain meaning when it exists and considering the Legislature's intent when interpreting ambiguous statutory text—results in court decisions that do not overstep the court's authority and applies the statute with the greatest level of conformity to how the Legislature intended the statute be applied.

Another reason the improper motive requirement should be adopted by the courts is that the improper motive requirement limits plaintiffs to those more closely related to the category of patients originally intended to be protected by EMTALA. The improper motive requirement does not limit plaintiffs to only those turned away from the

244. See *supra* notes 52–60 and accompanying text.

245. *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 269–70 (6th Cir. 1990)

246. *Id.* at 269, 271.

ED for their inability to pay, but the reasoning behind the requirement is much the same: EDs should not discriminate in providing patients emergency services. Adoption of the improper motive requirement preserves the level of care everyone is presently entitled to under EMTALA but will reduce the number of claims brought under the statute because the requirement weeds out improper claims.

Weeding out improper claims is both beneficial to the judicial system and fiscally beneficial to hospitals with EDs. Limiting EMTALA claims to proper plaintiffs is good for the judicial system because it results in a proper use of the law, which is a good unto itself. Additionally, the elimination of claims by improper plaintiffs reduces the burden those cases would have placed on the already overworked federal court system.

Limiting EMTALA claims to proper plaintiffs is good for hospitals with EDs because it will reduce the amount those hospitals spend on defending EMTALA claims. As was previously mentioned, hospitals presumably do not spend billions of dollars in defending EMTALA claims each year;²⁴⁷ therefore, the cost savings from the reduction in EMTALA claims will not make up for the billions of dollars in uncompensated care costs EMTALA creates. But much like the statutory amendments this Comment proposes, these savings created by reducing the amount of EMTALA litigation might slow the rate of hospital and ED closures, and thereby also slow the rate of ED overcrowding. The hospitals that stand the greatest chance of benefitting from the reduction in litigation costs are those that are on the border of solvency and insolvency. These savings should not be expected to have a significantly beneficial effect on hospitals facing -7% profit margins; thus, adoption of the Sixth Circuit's improper motive requirement is not a complete solution to the fiscal problems facing America's hospitals either. In order for the financial burden that EMTALA places on EDs to be lifted, Congress will have to take direct action to fund the care provided under EMTALA.

C. Congress Should Fund EMTALA

The most direct way to solve the financial and quality of care problems created by EMTALA's promulgation is to fund EMTALA. Other commentators have remarked that it is very unlikely that Congress will take any action that will increase the government's share

247. See *supra* Part V.A.

of health care costs,²⁴⁸ and this is likely true; however, given the serious consequences of continuing to require EDs to provide uncompensated care to the uninsured, the idea of funding EMTALA should be given serious consideration. This view was shared by the Emergency Medical Treatment and Labor Act Technical Advisory Group, which gave high priority status to its recommendation “that HHS act to support amending the EMTALA statute to include a funding mechanism for hospitals and physicians.”²⁴⁹

Reimbursing hospitals for the care they provide to uninsured people under EMTALA is the most direct way to stop patient dumping and thereby achieve the Legislature’s noble goal. The decision to engage in patient dumping is a fiscally motivated decision. If hospitals were compensated for the care that they are required by EMTALA to provide, then they would have no incentive to dump patients.

Some commentators might argue that funding EMTALA would provide a perverse incentive for individuals to forego obtaining health insurance and remain uninsured, either because they will receive better health coverage or free, although limited, health coverage. This is not the case because the minimal level of health coverage provided under EMTALA in combination with the fines imposed by the ACA’s individual mandate for not being insured²⁵⁰ provide a greater incentive to be insured than uninsured.

If EMTALA was funded, the level of medical care provided to individuals in EDs would remain the same—an appropriate medical screening and stabilization—and therefore uninsured individuals would not gain additional hospital care by remaining uninsured. Additionally, funding EMTALA would not open the doors of primary care physicians’ offices or other medical providers to the uninsured because EMTALA only applies to emergency medical care provided by EDs;²⁵¹ thus, non-ED medical care providers would have no new incentive to treat uninsured patients. Therefore, funding EMTALA would not remove the present incentive for uninsured patients to obtain insurance, namely a greater level of health coverage.

248. See, e.g., Diamond, *supra* note 32, at 292 (“Congress is unlikely to enact any amendment to the ACA that increases its costs . . .”).

249. EXTRACT OF FINAL REPORT OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT TECHNICAL ADVISORY GROUP TO THE U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES 27, 29 (2008).

250. 26 U.S.C. § 5000A(a)–(c) (2012).

251. See *supra* note 111 and accompanying text.

Furthermore, if EMTALA were funded, the ACA's individual mandate would still be in effect and through its fines continue to provide an incentive for people to obtain health insurance.²⁵² If necessary, these fines could be increased to reduce any incentive funding EMTALA might create to remain uninsured. Additionally, the funding mechanism could be purposefully structured to reduce any incentive it may create for persons to remain uninsured given a choice.²⁵³

VI. CONCLUSION

In 1986 Congress laudably enacted EMTALA to combat the lamentable rise in hospitals engaging in patient dumping, but this Act is Janus-faced. On the one hand, EMTALA opened the doors of EDs to everyone and in so doing turned EDs into the health care safety net for the entire United States. EDs became the one place that all insured, uninsured, documented, and undocumented people can receive a minimal level of health care in the United States. On the other hand, Congress's failure to provide a funding mechanism for the care that EMTALA requires EDs to provide and covering everyone under the statute, rather than limiting the statute to protect only the victims of patient dumping, has resulted in EMTALA unraveling the very safety net it creates.

Under the current system, the more uninsured patients an individual ED treats, the more debt that ED takes on, which in turn increases the chances for that ED to close. Once that ED closes, its patients, both insured and uninsured, seek treatment at the remaining EDs. Those EDs in turn must find a way to absorb the additional uncompensated care costs resulting from complying with EMTALA. Those hospitals that are already on the brink of insolvency due to the Medicaid and Medicare payment shortfalls will become insolvent when they try and absorb the influx of new uninsured and underinsured patients. Eventually those EDs, and possibly the entire hospital, will also close. And so the safety net continues to unravel.

If nothing is done to change the health care system and alleviate

252. See Diamond, *supra* note 32, at 268–69.

253. This Comment does not attempt to provide a detailed analysis for how the suggested EMTALA funding mechanism might be structured. This Comment merely posits that it is plausible that HHS could structure a funding mechanism to reimburse hospitals for care provided in accordance with EMTALA without creating too great of an incentive for individuals to be uninsured. See generally Lee, *supra* note 81, at 169–70 (2004) (suggesting two ways to fund care for uninsured and underinsured patients).

some of the financial burden placed on EDs, it is only a matter of time before EDs are a thing of the past. The statistics and studies clearly show the number of ED visits to be steadily rising and the number of EDs to be steadily decreasing.²⁵⁴ As more people use EDs for both emergent and non-emergent care, ED overcrowding is becoming more commonplace. The increase in ED overcrowding diminishes the quality of care every patient receives in the ED.

Emergency health care is too important to let the entire safety net unravel. This Comment recognizes that amending a statute is not an easy feat, politically or bureaucratically; however, considering what is at stake—preserving the minimum level of health care for all Americans, both from an accessibility and quality perspective—Congress should seriously consider amending EMTALA as proposed by this Comment or in a manner to reach the same ends that this Comment seeks.

This Comment directs a similar call to action towards the federal appellate courts. This Comment does not encourage the courts to become activist courts, but it does encourage them to give serious thought to adopting good law—the Sixth Circuit's improper motive requirement—in accordance with accepted canons of construction—considering legislative history when interpreting ambiguous language in a statute. The courts are not in a position to fix all of EMTALA's unintended consequences; however, they are in a position to give Congress some extra time to act.

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254. TRENDWATCH CHARTBOOK, *supra* note 22, at 32.

* J.D., 2015, Marquette University Law School; B.A., 2008, Augustana College. Thank you to the staff of the *Marquette Law Review* for their hard work and support in editing this Comment. I would also like to thank my wife for her unwavering support and understanding while I wrote this Comment and throughout my time in law school.