Emergency Medical Treatment and Active Labor Act, EMTALA

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The Emergency Medical Treatment and Active Labor Act, EMTALA, was passed in 1986 under the Consolidated Omnibus Reconciliation Act, COBRA, 1985, for providing emergency medical services to all, irrespective of financial or insurance status (American College of Emergency Physicians, 2018). Prior to this law, hospitals and care centers were dumping poor, uninsured patients onto safety net hospitals for emergency care. These patients were often sent without any treatment or even stabilization in severe cases, leading to adverse patient outcomes. A large segment of this population included minorities and unregistered immigrants. The EMTALA mandated three main obligations for hospitals that had an emergency department and received Medicaid funding, which are listed as follows:

1. A medical screening exam is to be provided for any person, irrespective of insurance, to determine a bona-fide medical emergency (American College of Emergency Physicians, 2018).
2. Once a medical emergency has been established, the hospital must treat or stabilize the patient (American College of Emergency Physicians, 2018). If neither is possible, then the patient should be appropriately transferred to a recipient hospital capable of handling that emergency. Appropriate transfer implies transfer with medical records, continued medical care during the transfer, and transfer to a properly equipped establishment.
3. Specialized recipient hospitals are obligated to accept such transfers (American College of Emergency Physicians, 2018).

The EMTALA mandate ensures that emergency medical treatment is provided to all without investigation into insurance or financial status. Compliance is monitored by the Centers for Medicare and Medicaid, CMS. Although EMTALA is fundamentally beneficial

to the public, it has come into controversy because the brunt of expenses is borne by the hospitals and emergency physicians since it is an unfunded health care mandate, causing many emergency departments to shut down (American College of Emergency Physicians, 2018). In addition, reimbursements through Medicaid are low and often declined based on the final diagnosis. This has led to a financial burden of $4.2 billion on physicians and hospitals in uncompensated bills (The Emergency Medicine Residents' Association, n.d.). Consequently, there are reports of EMTALA violations and inappropriate transfers. This paper examines the EMTALA policy to analyze its impact and drawbacks, and offers recommendations on possible solutions to problems associated with this policy.

EMTALA: Its Impacts and Drawbacks

All hospitals funded by Medicare are contractually bound to implement EMTALA in their emergency departments. This mandate ensures that no patient, irrespective of insurance or ability to pay, will go untreated in an emergency or during active labor. Before this law, the Hill-Burton Law of 1946 mandated free treatment to the poor or uninsured patients for 25 years or more in exchange for government funding (Friedman, 2011). As this time period expired and hospitals were free of obligation, stories emerged of severely ill patients being turned down for treatment or dumped onto public hospitals for lack of insurance or money. A 1986 publication noted that 24% of patients sent to public hospitals in Chicago were unstable, and all of them were uninsured (Friedman, 2011). The passage of the EMTALA law provided relief to all those patients who were in dire need of emergency treatment but could not afford it.

However, this mandate was not federally funded, and partial funding was provided by Medicaid with low reimbursement rates. In addition, strict Medicaid policies made reimbursement difficult, especially for expensive screening tests, and reimbursement was

given based on final diagnosis, not presenting complaints. This meant that for treating a patient for chest pain under EMTALA, Medicaid would compensate only if the patient had a heart attack and not for other causes, such as heartburn. It put considerable financial burden on the hospitals and emergency physicians, as they had to pay out of their own pockets for non-compensated patients. With the rise of uninsured Americans and a burgeoning immigrant population, many of them unregistered, which resulted in a considerable financial burden. Consequently, even after the passing of the law, compliance is dismally low, with about 40% of hospitals under investigation for EMTALA violation since 2011 (Hsuan, Horwitz, Ponce, Hsia, & Needleman, 2017).

The five main reasons for non-compliance by hospitals are highlighted below.

1. *Financial Pressure*: As noted above, the treatment of uninsured and poor patients is poorly compensated by insurance, and remaining cost is borne by physicians and hospitals. A 2003 American Medical Association survey found that emergency physicians provide $138,000 of free EMTALA care annually (American College of Emergency Physicians, 2018). Therefore, hospitals view these cases as burdensome, especially in states without expanded Medicaid and where reimbursement policies are strict with low rates.
2. *Complex Laws*: Most emergency physicians are aware of the specifics of EMTALA, but there are certain gray areas, such as with psychiatric patients (Hsuan et al., 2017). Also, physicians in rural hospitals may not be specialists and may be unaware of diagnostic and transfer protocols under EMTALA, making them reticent in taking such cases.
3. *High Volume of Referrals to Recipient Hospitals*: Due to overloaded emergency departments, recipient hospitals can decline EMTALA patients (Hsuanet al., 2017). This deters referring hospitals from taking on sick EMTALA patients.

4. *Inter-Hospital Relationships*: To maintain transfer contracts, some recipient hospitals do not report minor violations by partner hospitals, encouraging them to decline uninsured patients.
5. *Physician Priorities*: Many physicians mistakenly believe the liability of violation lies with the hospital only, and so they refuse patients (Hsuanet al., 2017).

Another unintended impact of EMTALA is hospital and physician liability. Patients can file civil suits for EMTALA violations. Liability costs are high, and many states exempt EMTALA from tort reform laws, making it more likely for hospitals and physicians to pay (Hsuanet al., 2017). Rarely is a hospital removed from Medicare due to a violation.

Solutions

The most pressing concern is relief of financial burden on hospitals and physicians. To this end, the Academy of Emergency Physicians has proposed reduction of treatment costs of uninsured patients and reduced liability costs to physicians (The Emergency Medicine Residents' Association, n.d.). As emergency physicians treat uninsured patients without knowledge of prior history, they are more vulnerable to malpractice claims. Therefore, they also propose liability reforms to protect physicians and hospitals from fraudulent EMTALA violation claims. The American College of Emergency Physicians has helped in legislation of the Healthcare Safety Net Enhancement Act of 2015 for this purpose (The Emergency Medicine Residents' Association, n.d.). In addition, the federal government should also provide funds for treatment of uninsured patients as Medicaid does not fully cover treatment costs.

Financial burden will also be eased with reforms in Medicaid policies, specifically reimbursement of treatment based on presenting complaints rather than the final diagnosis. Medicaid should also reimburse for more expensive screening tests in patients with medical

emergencies. Apart from Medicaid and the federal government, corporations can also contribute to treating uninsured patients as part of corporate social responsibility. For instance, pharmaceutical and surgical companies can provide free medicines and equipment for treatment of patients under EMTALA, reducing the burden on hospitals for expensive medicines.

As far as knowledge and complexities are concerned, certain steps, such as integrating EMTALA law information with the electronic health records, will help avert clerical violations (Hsuan et al., 2017). Educating physicians in rural hospitals and building trustful inter-hospital relationships will bolster confidence in accepting uninsured patients.

Conclusion

Hence, this paper has analyzed the impact of EMTALA to provide democratic emergency health care to all, irrespective of insurance status or ability to pay. All hospitals receiving Medicare are obligated to provide free emergency treatment to all patients. Though a noble concept, its key flaw is inadequate funding. Compensation through Medicaid is low or none, and the onus of treatment costs fall on physicians and hospitals. Consequently, many emergency departments have shut down, and many hospitals reject uninsured patients in violation of the EMTALA law. Therefore, this paper recommends reforms in Medicaid policies, liability laws, low treatment costs for uninsured patients, reduced liability costs and federal or private funding for treating uninsured patients in order to improve functional and patient outcomes through EMTALA.

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