EMTALA: The Evolution of Emergency Care in the United States

Authors: Heather L. Brown, DMSc, PA-C, DFAAPA, and Thomas B. Brown, BSN, RN, Atlanta, GA

CE Earn Up to 7.5 Hours. See page 467.

Contribution to Emergency Nursing Practice

- The current literature on Emergency Medical Treatment and Active Labor Act (EMTALA) indicates that although the statute has existed in law since 1986, many health care practitioners are unfamiliar with the requirements of the Act and how they apply to them.
- This article contributes a clear discussion of the history of the Act and its implications for health care providers.
- Key implications for emergency nursing practice found in this article are an understanding of the EMTALA statute and its consequences for anyone working in an emergency medicine environment.

Since the implementation of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, patients seeking care in emergency departments have had protections against denial of care based on financial issues. The Act sought to end economic discriminatory practices[1] that led to medical care being withheld based on likelihood of payment for services, which too often had disastrous consequences for those who fell through the cracks of these financially motivated practices.[2] Under EMTALA, patients were mandated to receive, at minimum, a screening examination and necessary stabilization prior to any discussion of discharge or transfer to another facility to provide a threshold for which all patients would be entitled to emergent care when needed.[3] In essence, it was the first federal law that established an affirmative right with regard to health care, ensuring that basic treatment for medical emergencies was provided to all people, regardless of their ability to pay for treatment.[1]

Heather L. Brown is Assistant Adjunct Professor, Department of Physician Assistant Studies, College of Health Professions, Mercer University, Atlanta, GA.

Thomas B. Brown is Nurse Navigator, Structural Heart and Valve Program, Emory University, Atlanta, GA.

For correspondence, write: Heather L. Brown, DMSc, PA-C, DFAAPA, 165 Thompson Place, Roswell, GA 30075; E-mail: hbrownpac@gmail.com.

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Old Practices in Emergency Care

A patient presents to the emergency department at a local hospital with a complaint of chest pain. The initial evaluation of the patient in the triage area includes registration of the patient and certification of insurance coverage. The patient is discovered to be insured by a policy from a health care insurance carrier that does not have a contract with the hospital. The patient, who is still having chest pain, is told to go to a hospital that accepts that patient's insurance for payments and is sent out of the emergency department without an evaluation or treatment and goes home. The patient arrives at another facility later that day after having been found unconscious at home. It is determined that the patient had a heart attack earlier in the day, and the damage to the patient's heart is massive at the time of the second hospital arrival. The patient subsequently dies of injuries to the heart.

Today, this vignette would be an unlikely outcome for a person seeking emergency medical care, but this scenario was commonplace in the 1980s in the United States. At that time, hospitals routinely refused medical care to patients presenting to emergency departments based on nontherapeutic reasons.[3] As a matter of policy, facilities would turn away uninsured patients, a practice called "dumping," in which unstable patients were turned away to avoid the hospital having to treat patients who were likely to be unable to pay.[4] Before receiving any evaluation by clinicians, patients were screened by registration agents to determine if they had health insurance coverage and if they were likely to be able to pay their bills. These so-called billfold biopsies led to nonclinicians making decisions about whether people seeking care would be attended to or not, as poor financial risks to the hospital were referred to other facilities before any medical care had been rendered.[3] Patients were refused life-saving care outright or swiftly transferred to other facilities that provided help regardless of ability to

pay. The newspapers were filled with articles of atrocities committed to needy patients,[4] and stories of patients refused life-saving care abounded.[3] Feeling compelled to do something to protect the public, ensuring that seriously ill people would not be abandoned outside facilities with no access to care, Congress took up the issue, and EMTALA was the result of its work.[5]

The Advent of EMTALA

In response to this bad behavior on the part of medical facilities and negative patient outcomes that resulted from it, Congress acted in 1986, with the inclusion of the EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1986.[2] This Act included legislation addressing companies providing continuing access to health insurance coverage when employees no longer qualified for their employer-sponsored plan for reasons including leaving employment, becoming Medicare eligible, and a reduction in hours worked. Also, this federal law aimed to change the unacceptable acts of hospitals in the 1970s and 1980s, with regard to dumping of patients and failure to act with a duty to treat patients, basing those decisions on financial—not clinical—reasons.[1] EMTALA is a departure from previous legal precedents that did not ascribe a clear duty of physicians to treat patients who are not yet their patients, which had been common practice for health care providers in this situation before EMTALA.[2] In the past, the facility and/or the provider would not have had to provide any care to a patient who was presenting for emergency evaluation if it was decided that the presenting patient did not have the ability to pay for services, as no clear duty existed for this patient. Before EMTALA, the courts had continued to allow providers wide latitude in choosing whom they elected to treat. However, after its inception, the new law carved out a clear exception to the no-duty principle for cases of emergency medical care, mandating that a duty to treat a patient does exist for emergency health care providers and facilities for all patients who present for care.

EMERGENCY MEDICAL CONDITIONS

The statute is clear in what constitutes an emergency medical condition, by defining it as "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…placing the health of the individual…in serious jeopardy…or serious dysfunction of any bodily organ or part."[2] In addition, medical knowledge is not necessary to ascertain that an emergent medical condition is occurring; rather, the "prudent layperson" standard is used, allowing a reasonable person with no medical training to decide that the situation is emergent, and care is needed.[6] Thus, under EMTALA, a layperson can deem a patient presenting to the emergency department as needing emergency care and evaluation, and a provider would be duty-bound to provide the required care.

THE "COMES TO" TEST

The literature and court opinions about EMTALA further clarify what presenting to the facility for emergency evaluation means. The law itself includes the wording "comes to the emergency department," which has been a source of debate on its intended meaning since passage of EMTALA in 1986.[3] Federal regulations, issued in 2003, aimed to help clarify that the "comes to" test should be interpreted liberally.[2] If a patient presents to the hospital campus (or within a 250-yard radius of it) for emergency care, the patient has satisfied this provision, and the duty to treat the patient is in force, even if the patient did not actually enter the emergency department proper.

What the Law Requires

As drafted by Congress, EMTALA is written as a highly detailed statute, with provisions in place in its 10 subsections that clearly spell out the obligation for facilities and providers who receive Medicare reimbursement, with regard to patient emergency care.[2] Specifically, for any hospital that falls under the requirement, any patient who presents with a suspected emergent condition requesting care, providers must perform a screening evaluation and provide treatment to stabilize any conditions recognized in that examination, without regard for the patient's subsequent ability to pay for the care rendered.[1] There are 2 obligations created in statute: screening and stabilization. All patients who present to EMTALA-covered hospitals must receive a medical screening examination from a provider.[3] If an emergent condition is detected through this evaluation, the hospital must continue care to provide stabilization of that problem. Further, there is also discussion for the safe provision of appropriate transfers of patients to other facilities, as needed, after the initial evaluation process.[2]

SCREENING EXAMINATION

As it clearly rejected the no-duty principle, subsection (a) of the law requires all hospitals to initiate appropriate care for all presenting patients in this potential medical emergency

via the pivotal requirement of the patient screening examination.[2] Under EMTALA, when a patient presents to the emergency department for care, an "appropriate screening exam" must be completed by a provider.[3] The statute is intentionally vague on who is qualified to provide this mandatory examination, and the wording states that "non-physician practitioners" are permitted to complete this task, but the delineation of who a facility intends to allow to work in this capacity must be formally designated in hospital policies. There are many potential ways that a facility can attempt to minimize this requirement, as the wording of the law is up for interpretation. Examinations may be cursory, lack ancillary testing, or fail to identify the emergency medical condition at hand in an attempt to minimize impact to the hospital. But the clear directive included in subsection (a) is clear: All facilities must initiate provider screenings of people who request their help for any potential emergency medical problem.[2]

STABILIZATION

Once patients have received their initial medical screening examinations, subsection (b) of the EMTALA further requires that patients be stabilized with regard to the presenting condition.[2] Specifically, if the examination has revealed an emergent condition, the hospital has an obligation to the patient to stabilize the patient prior to transfer.[3] In the statute's language, "transfer" refers to any movement of the individual outside the hospital's facility, including discharge from the premises.[2] This second requirement of EMTALA—stabilization—requires that the patient is provided sufficient treatment to stabilize the emergency condition.[4] The word "stabilize" is defined as the amount of treatment "as may be necessary to assure, within reasonable medical probability, that no material deterioration…is likely to result from or during the transfer…from a facility."[2] There is obviously room for interpretation here on the amount of treatment that is mandated on the part of EMTALA for each patient. If patient care would ever be called into question from a professional standard-of-care perspective, the reasonable prudent-person standard would be used for the determination of an appropriate level of stabilization, similar to professional negligence-litigation standards.[3]

APPROPRIATE USE OF TRANSFERS

Finally, the provision for appropriate medically necessary transfers is addressed in EMTALA. At the time the law was drafted, it was estimated that almost 90% of transfers were undertaken for economic reasons, with 24% of those patients qualifying as unstable when transferred.[1] The documented rate of deaths associated with these transfers was triple of that for other patients. As the inappropriate, financially-motivated transfer of patients was one of the initial drives for enactment of the law, there are limited provisions for transfer of patients.[3] In the event of a transfer, a provider must attest—with a signed certification—that the benefits outweigh the risks for the patient to be transferred to another facility.[2] This transfer also must be undertaken for medical necessity—such as definitive specialty care not available at the current facility—under the professional standards of care for the patient's individual condition. And, finally, the facility that the patient is being transferred to must accept the transfer to complete the transaction.[3]

Effects of EMTALA on Emergency Care

Since the passage of EMTALA and the implementation of the statutes that ensure that people have prompt access to emergency health care, the new law has clearly affected emergency departments in the United States. Although, overall, the argument would often be made that the Act has had a positive impact on access and equality with regard to care, there are other factors to consider.

HIGHER UTILIZATION

One of the major negative downstream outcomes observed is increasing use of the emergency department as an option for access to 24/7 health care. From 1997 to 2007, ED visits increased more than 14%, and most emergency departments operated at or above intended capacities.[7] Both the National Center for Health Statistics and the US Department of Health and Human Services Office of the Inspector General (OIG) have commented on the unintended consequences of EMTALA causing overcrowding and overuse of emergency departments, as patients seek care "exploiting hospitals' fear of violating EMTALA." Commentators have opined that the shuttering of many trauma centers, maternity wards, and tertiary hospital facilities can be linked to the financial burdens placed on hospitals because of EMTALA obligations.[5] Because of all the effects of high ED use and subsequent financial consequences for hospitals that are now required to take care of all patients who present, regardless of ability to pay, EMTALA cannot be excluded as a player in the complicated financial health care world of today.

LITIGATION

As a second consequence of EMTALA, patients now have an additional avenue with which to pursue litigation if unhappy with their care in the emergency department of a hospital.[4] Under the federal statute, health care providers are not subject to civil liability under EMTALA. Violations of the act are enforced by the OIG and allow for civil monetary penalties, levied against both providers and facilities. Generally, failing to provide a mandated screening examination or inappropriately documented transfer of a patient was the cause in most successfully prosecuted cases.[3] Documented lack of appropriate screening examination (75%) and insufficient stabilization (42%) were noted in EMTALA violation case results from 2002 to 2015 from the OIG.8.[8] Penalties for violation of EMTALA are stout, costing up to $50,000 per infraction and/or termination from participation in Medicare.[4] But despite the clear wording of the law, its requirements, and the stiff penalties, violations still occur. Lack of understanding of the law and its applications and financial pressure from administration are cited as reasons for these infractions on the part of providers and hospital staff.[4] Although the statute is separate and distinct from tort litigation against the provider for claims of poor-quality care, it is possible for both types of claims to be pursued by a patient.[2] In some states, undertaking an EMTALA violation investigation may be beneficial to their tort claim.[4]

Conclusion

Enacted in 1986, the emphasis of EMTALA is to prevent hospitals from refusing to provide medical care to patients for financial reasons.[8] The law provides for an obligation of duty to patients who present for emergency care, regardless of their ability to pay for services rendered for that care.[2] In the decades since its passage and subsequent implementation, the law has acted as safeguard for persons in the United States against economic discrimination and has undoubtedly saved many patients from the repercussions of denial of care.[1] Although there have been some negative outcomes ascribed to the statute, including overuse by patients,[7] EMTALA stands out as the first law to put patient care above financial concerns, moving our health care system toward more equal and fair basic access for all.

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