

Insight



The Emergency Medical Treatment and Active Labor Act (EMTALA) and Its Effects

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The Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986, is intended to prevent hospitals from “patient dumping” indigent or high-risk patients by transferring them to public hospitals or refusing to provide care.[1]

EMTALA requires that all Medicare participating hospitals with Emergency Departments (EDs) provide stabilizing emergency care for all patients seeking help (including women in labor), regardless of their insurance status or ability to pay.[2] These hospitals are required to examine everyone who comes through the doors of the emergency department (or, in fact, enters hospital property seeking care), and scan them for emergent medical conditions. The hospital is then required to either treat or stabilize the patient.[3]

Ensuring a patient is stabilized requires that, within reasonable medical certainty, no material deterioration in the patient’s condition should occur during transfer or upon discharge from the hospital. For purposes of EMTALA, any transport of a patient is considered a “transfer” – even if the patient is going home, therefore all transfers must also be accompanied by a request for transfer by the patient, along with informed consent.[4] Alternatively, a certification by a physician could accompany the transfer order if the benefits of transferring the patient outweigh the risks, and that the transfer is appropriate. For example, if the transfer is to a hospital with a specialty burn unit or a children’s hospital.

On the other hand, EMTALA also requires that all hospitals with specialty units, such as a burn ward, accept transfers to those units to the extent of their capacity. This restriction is in place to prevent what is known as “reverse dumping,” whereby a specialty hospital, which might lack the appropriate capacity, sends patients with specific needs back to a referring hospital without the capacity to meet those needs.[5] If a hospital is unable to accept a transfer because of a genuine lack of capacity, but the patient has already arrived, the EMTALA requirements that the patient is stabilized before transfer still apply, even if the patient has not been formally admitted to the hospital.

Enforcement

Any hospital that accepts Medicare payments must comply with EMTALA requirements. This means that nearly all hospitals in the United States, except specific children’s hospitals and military hospitals, are subject to the law. Any hospital found to be in violation of EMTALA is liable to lose all Medicare reimbursements as a part of the terms of Medicare’s “provider agreement” with the hospital.[6]

For an individual to file a legal claim under EMTALA, there need be no injury-in-fact: the mere violation of EMTALA is enough for a plaintiff to win a lawsuit, even if that patient did not suffer any physical harm as a

result of the violation. In these cases, the burden of proof is on the hospital to show that there was no violation of the statute.[7]

Because of the unusual shift of the burden of proof to the defense, coupled with the fact that the plaintiff need not prove an injury, hospitals in EMTALA lawsuits are in a uniquely difficult position of having to prove a negative. This heavy burden has led to an unprecedented number of large settlements by hospitals accused of having violated EMTALA. Predictably, the result of these easy settlements has been an explosion in EMTALA cases, where the number of claims filed against hospitals increased by over 1000 percent in the first 10 years after the law was implemented.[8]

Conclusion

EMTALA guarantees that care is provided to all those in need who go to an American Emergency Department seeking help. However, the law has also created large unfunded liabilities for hospitals in the form of uncompensated care. Additionally, hospitals face the threat of litigation for failure to comply with the law, which could result not only in damages paid to the plaintiffs, but also in a loss of reimbursement for all Medicare patients treated in that hospital. Because of these incentives, and the litigious opportunities for bad actors, hospitals face legal costs and the added burden of providing defensive medicine and unnecessary care for the sake of avoiding excessive legal penalties. All of these costs are eventually passed on to other patients in the form of the increased cost of obtaining care.

[1] <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/>.

[2] 42 U.S.C §1395dd.

[3] <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/>.

[4] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/>.

[5] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/>.

[6] <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/>.

[7] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/>.

[8] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/>.