PLEASE RESUSCITATE! HOW FINANCIAL SOLUTIONS MAY BREATHE LIFE INTO EMTALA

I. INTRODUCTION

*Modern Healthcare* reported an accusation that a Kaiser Permanente hospital had dumped patients in the Los Angeles area.\(^1\) According to the report, “[t]he accusation is one of ten alleged incidents of patient dumping by Los Angeles hospitals being pursued by the city attorney’s office. In the past year and a half, the office has received about 70 reports of homeless patient dumping.”\(^2\)

On August 22, 2007 the *Los Angeles Times* reported that police were investigating whether two more Los Angeles hospitals dumped patients on Skid Row, including one mentally ill man who allegedly was left on the street without prescription medication.\(^3\)

Patient dumping is “the refusal of a hospital to provide necessary treatment to an emergent patient or a woman in active labor on a basis (primarily the inability to pay for services) unrelated to the hospital’s capability to provide care or the patient’s need for care.”\(^4\) In response to the rising incidence of patient dumping, in 1986 Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the anti-patient dumping act.\(^5\)

First, Part II of the comment provides an overview of EMTALA then, Part III discusses the practice and problems of EMTALA and finally, Part IV provides proposed reforms of EMTALA. The proposals

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2. Id.
include the suggestion to abolish EMTALA and a proposal to allow a private cause of action against physicians. This comment argues that it would be better to assist hospitals and health care providers through financial support, as provided by two acts currently pending in Congress, and to encourage hospitals, via financial incentives, to offer free preventive care such as urgent care centers close to emergency departments.

II. EMTALA: AN OVERVIEW

A. Background

Patient dumping is a long-standing problem. This problem did not become widely recognized, however, until the 1980s when several studies investigating patient dumping were publicized. Some studies estimated that “emergency facilities dump[ed] at least 250,000 patients annually.” Another study in Chicago “reported that transfers [of patients] from private hospitals to public hospitals increased from 1295 in 1980 to 6769 in 1983, with 24% [of the patients] being unstable at time of transfer.”

A rising number of uninsured patients had led hospitals to dump patients at increasing rates. The increased number of uninsured patients “place[d] a strain on the ability of hospitals to provide


7. See e.g., Thomas A. Gionis, Carlos A. Camargo, Jr., & Anthony S. Zito, Jr., The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 52 AM. U. L. REV. 173, 175 (2002). “A man with a knife wedged against his spine was transferred from an emergency department because he did not have insurance. The transferring hospital refused to remove the knife unless he paid $1,000 cash in advance of treatment.” Id. “A woman mistakenly identified as uninsured was turned away from two private hospitals during the early stages of giving birth—even though fetal monitoring indicated fetal distress. By the time the patient reached the county hospital, her child [had] died.” Id.


uncompensated care while remaining solvent.”  

One study cited lack of insurance as the reason for 87% of the transfers. 

In earlier years, before Medicare and Medicaid were instituted, indigent and uninsured patients were treated under a system of charity care. Because hospitals and physicians were free to charge their patients however they wanted, they charged wealthy patients a premium and charged low income patients at discounted rates. If the hospitals were able to attract a sufficient number of wealthy patients, they could afford to provide a certain amount of charity care. 

After the enactment of Medicare and Medicaid in 1965, however, “the government’s limitations on reimbursement rates for Medicare and Medicaid patients [made] it even more difficult for hospitals to provide services to uninsured or underinsured individuals.” Because of economic disincentives, hospitals had little choice but to dump patients. Congress responded to this widespread practice of patient dumping by enacting EMTALA. As Michael Bilirakis, a Representative from Florida stated: “We cannot allow a health care system as advanced as ours to provide emergency care only to those who can pay. [EMTALA] will ensure that hospitals live up to their fundamental responsibilities to the public.”

B. The Statute

EMTALA helps to prevent hospitals from dumping indigent or uninsured patients with emergency medical troubles. Such dumping usually takes the form of transferring the patient to a public hospital. Although EMTALA intends to deter the dumping of financially undesirable patients, the statute covers more than indigent or uninsured

12. Id.
14. See Victoria K. Perez, Comment, EMTALA: Protecting Patients First by Not Deferring to the Final Regulations, 4 SETON HALL CIR. REV. 149,151 n.12 (2007) (noting that the common law did not provide patients with a legal right to medical treatment, and likewise did not impose on hospitals an obligation to provide treatment).
16. Id at 706.
17. Id.
18. Schaffner, supra note 11, at 1025.
19. Dame, supra note 8, at 5.
21. Liang, supra note 5, at 205.
All hospitals that participate in the Medicare and Medicaid programs fall under EMTALA, which means “virtually every hospital in the United States[,]” and the statute protects “any and all patients who come to the hospital’s emergency room.”

EMTALA imposes the following duties on hospitals: (1) to provide an “appropriate medical screening examination;” and (2) “to stabilize or appropriately transfer patients.” The purpose of the screening examination is to determine whether there is an emergency medical condition, i.e., a “condition of severe, acute symptoms that the lack of immediate medical attention could reasonably result in serious jeopardy of health, impairment of bodily function, or dysfunction of any organ or body part.” If an emergency medical condition exists, the hospital must either “treat and stabilize the condition” or make an “appropriate transfer of the patient.” A patient can be transferred before stabilization at his or her request or upon the physician documenting that “the benefits of transfer reasonably outweigh the risks of transfer to the health of the individual.” An appropriate transfer “requires the receiving facility to have available space and personnel to treat the patient, agree to accept the patient, and agree to provide treatment.”

In essence, courts have held that, under EMTALA, liability will attach “where a hospital fails to provide an appropriate medical screening examination, fails to stabilize an emergency medical condition, or violates EMTALA’s transfer rules, regardless of a patient’s ability to pay.”

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22. SUSAN S. ROBFOGEL, JUDITH M. NORMAN & MARION BLANKOFF, ACCESS TO HEALTH CARE, in 2 TREATISE ON HEALTH CARE LAW 11.01, 11-21 (Alexander M. Capron, & Irwin M. Birnbaum, eds., 2008).
23. Id. at 205.
24. Id.
26. Id. at 553–54 (citing 42 U.S.C. § 1395dd(e) (1994)).
27. Id. at 555–56.
28. Id.
29. Id.
30. Id. at 555.
31. Id.
Hospitals can face several penalties imposed by the federal government for violating EMTALA. One of the penalties is being excluded from the Medicare and Medicaid programs. Another penalty involves a fine up to $50,000 for each violation. Hospitals with fewer than 100 beds, however, are limited to $25,000 for each violation. Physicians may also “be subject to similar exclusions and fines of up to $50,000 for violation of the statute’s mandates if their violation is ‘gross and flagrant’ or repeated.” And, a “[p]hysicians’ duty to treat under EMTALA is voluntary to the extent that it only applies if a physician has contractually agreed to provide emergency room services to a hospital.”

A patient who is harmed by a violation of EMTALA also has a right to sue the responsible hospital, and she or he may seek both injunctive relief and damages. “To state a claim, the plaintiff must allege that she went to the emergency room of a Medicare-provider hospital seeking treatment, and the hospital either failed to screen her in the same way as other patients, or the hospital discharged or transferred her before the medical condition was stabilized.” Moreover, a hospital that receives an improperly stabilized patient from another hospital in violation of EMTALA not only may recover damages from—and get an injunctive protection from—the violating hospital but is required to report the purported violation to the Health Care Financing Administration. However, in a majority of jurisdictions, a

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33. Liang, supra note 5, at 206.
34. Id.
35. Id.
36. Id.
38. Id. (citing Hiser v. Randolph, 617 P.2d 774 (Ariz. Ct. App. 1980)).
39. See Schaffner, supra note 11, at 1027 (citing Brenord v. Catholic Med. Ctr., 133 F. Supp. 179, 185 (E.D.N.Y. 2001). See also Reynolds v. Maine General Health, 218 F.3d 78, 83 (1st Cir. 2000) (“This provides a remedy for individuals in situations where a claim under state medical malpractice law may not be available. For example, courts routinely reject the argument that plaintiffs bringing claims under EMTALA must meet the procedural restrictions necessary for state malpractice claimants.”).
40. Liang, supra note 5, at 206.
III. EMTALA: IN PRACTICE

A. Patient Dumping: A Persistent Problem

Despite the severity of these penalties, the practice of patient dumping is alleged to persist. There are few statistics published about patient dumping, but the available data suggests, and at least one commentator claims, that the practice of patient dumping is a continuing phenomenon. Table 1, taken from Lawrence Bluestone’s article, is based on data from the Office of Inspector General (OIG), one of the agencies within the Department of Health and Human Services (HHS) responsible for enforcing EMTALA.

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41. EMTALA, 42 U.S.C. § 1395dd(d)(2)(A) (2000) (stating that “[A]ny individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.”). See Lawrence Bluestone, Comment, Straddling the Line of Medical Malpractice: Why There Should Be A Private Cause of Action Against Physicians Via EMTALA, 28 CARDOZO L. REV. 2829, 2837–43 (2007) (noting that EMTALA is cited in many opinions preventing a private right of action against the individual).

42. Schaffner, supra note 11, at 1028.

43. See id. (Suggesting that “there have been no comprehensive data monitoring patient dumping since EMTALA was enacted.”). See also Bluestone, supra 41 at 2837 (stating that “[s]ince the passage of EMTALA, statistical compilations as to the continued existence of patient dumping in hospital emergency rooms have been sparse.”).

44. See Bluestone, supra note 41, at 2837 (“[T]he data that is available, along with well reasoned inferences, suggest that the phenomenon persists.”).

45. Id.

46. Id.
Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Investigations Conducted</th>
<th>Number of Confirmed Violations</th>
<th>[%] of Investigations Resulting in Confirmed Violations</th>
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<td>370</td>
<td>102</td>
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<td>467</td>
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<td>174</td>
<td>38.84%</td>
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<tr>
<td>1998</td>
<td>412</td>
<td>168</td>
<td>38.35%</td>
</tr>
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</table>

Since the enactment of EMTALA, there have been few statistical compilations regarding the practice of patient dumping in hospital emergency rooms.\(^{47}\) Table 1 shows an increase in the incidence of patient dumping. It appears that patient dumping is far from having been eradicated by EMTALA.

B. EMTALA’s Problems

1. Financial Impact

EMTALA is an unfunded mandate, and it has created controversy by affecting hospitals, and by allegedly exacerbating problems in “an emergency medical system that is ‘overburdened, underfunded and highly fragmented.’”\(^{48}\) EMTALA provides “no method or funds”\(^{49}\) to compensate providers for the free care they give in complying with EMTALA requirements. Even though Medicare and Medicaid pay hospitals a small amount to compensate for losses incurred for treating indigent illegal immigrants,\(^{50}\) “the compensation is partial and indirect, and goes only to hospitals rather than to physicians or other individual providers.”\(^{51}\) Physicians and hospitals suffer because uninsured and Medicaid patients take advantage of EMTALA’s mandate to screen

47. Bluestone, supra note 41, at 2837.
51. Id.
patients, thereby clogging the emergency departments (“EDs”) even with routine medical problems.52 Even where the EDs obtain preauthorization for services, claims are often denied.53

Hospitals are compensated for less than half of the emergency room care they provide.54 According to a 2001 Patient Care Physician Survey, the enactment of EMTALA has had a negative impact on physician income.55 An Institute of Medicine report alleges that insured and paying hospital patients are also bearing some of the cost of EMTALA, in the form of higher rates, and that these increasing rates contribute to inflation.56

2. Emergency Department Overcrowding

Financial pressures have also caused hospitals to merge and close facilities, contributing to emergency room overcrowding.57 Even during times when emergency care increased, the number of emergency rooms decreased.58 A 2006 American Hospital Association survey of hospitals revealed that “50 percent of responders reported the perception that their EDs were at or over operating capacity.”59 Numerous commentators have criticized EMTALA for being ineffective at deterring patient dumping.60 One blames EMTALA for ED overcrowding.61 Such overcrowding may indeed be exacerbating the

52. Id.
55. Kane, supra note 53 (discussing how EMTALA has had a negative impact on physician income as seen in “[t]he PCPS [which] is a nationally representative survey of post-residency, non-federal, patient care physicians that is conducted via mail and phone interviews.”).
56. Institute of Medicine, supra note 54.
57. Id.
58. Id.
60. Bluestone, supra note 41, at 2829.
patient dumping problem by increasing the pressure on EDs to dispose of their patients by whatever means may be available. EDs are at the mercy of indigent patients who are aware of their right to a medical screening examination under EMTALA, and who abuse this right by visiting the ED with non-emergency ailments. This phenomenon, some commentators claim, has caused significant financial strain on EDs and has led to the insolvency of some. Laura D. Hermer, a Research Professor for the Health Law and Policy Institute, identifies systemic problems in hospital emergency care units, and implies that EMTALA may be to blame. She cites a 29% increase in the number of ED visits, closures of EDs and entire hospitals, the absence of surplus capacity in 90% of all hospitals, and the unavailability of malpractice insurance in several states as indicators of serious trouble.

3. Lack of Enforcement

Since its enactment in 1986, EMTALA has been perceived as minimally effective in preventing patient dumping. The Office of the Inspector General has been heavily criticized for being ineffective in monitoring and enforcing EMTALA violations. At least two commentators have observed that patient dumping violations have been increasing and that both the number of investigations and the number of penalties imposed have been increasing significantly more slowly. These commentators have both argued that these statistics suggest that enforcement is inadequate.

Another alleged problem with EMTALA is that, even where violations were noted, enforcement agencies “rarely enforce[d] penalties for EMTALA violations.” These agencies seldom imposed civil penalties and they closed over half of the reviewed cases without assessing any penalties. One court stated, “[a]lthough a hospital’s violation of EMTALA’s provisions theoretically can result in the termination of that hospital’s provider agreement . . . termination generally does not occur in practice so long as the hospital takes

62. Id. at 723.
63. Id. at 716.
64. Id. at 717.
65. Id.
66. Schaffner, supra note 11, at 1028.
67. Bluestone, supra note 41, at 2839 (“[B]etween the inception of EMTALA and 1998 patient dumping had increased 683%, with investigations increasing by approximately 390%.”). See also Schaffner, supra note 11, at 1028–29.
68. Schaffner, supra note 11, at 1029.
69. Id.
corrective action.”70 Admittedly, some of these allegations fall far short of proving that enforcement is lax—frivolous complaints could be responsible for the lack of severe penalties—but there is general consensus among the commentators that hospitals are not being held adequately accountable.

Finally, because EMTALA’s requirements are complex and confusing, it is difficult for hospitals to comply with them.71 This is especially true when there is a lack of uniformity among courts in interpreting EMTALA.72 “Some courts have interpreted EMTALA as a strict liability statute.”73 Further, federal circuit “courts have [been] split as to the appropriate standard of care with respect to the duty to perform an appropriate medical screening,”74 with some applying an objectively reasonable standard75 and others a subjective standard76 for determining compliance. The problem with a vague standard is that it leads to confusion and individuals may bring EMTALA claims that are more properly classified as malpractice claims.77

4. Amendments to Improve EMTALA

Because of these challenges and because of numerous complaints from hospitals and doctors claiming that EMTALA regulations “were ‘onerous and confusing,’ and exposed them to needless litigation and

70. Id. (citing St. Anthony Hosp. v. HHS, 309 F.3d 680, 693 (10th Cir. 2002)).
72. Schaffner, supra note 11, at 1029; see also, 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, 659 (2007).
73. Schaffner supra note 11, at 1031 (“[T]he Tenth Circuit noted that under EMTALA the hospital must provide medical screening after the patient requests it, and once a request for emergency care has been made, the burden is on the hospital to show that the patient either refused to consent to treatment or withdrew the request.”).
74. Id. at 1031–32.
75. See id. (e.g., “The First, Ninth, and Eleventh Circuits have applied an objectively reasonable standard for determining compliance with this requirement, calling for a larger obligation on the part of the physician and importing a reasonableness requirement into EMTALA.”).
76. Id. at 1032 (“The Sixth, Eighth, Tenth, and D.C. Circuits apply a subjective standard, drawing from legislative intent and the plain text of the Act to determine the meaning of appropriate medical screening examination.”).
77. 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, 659 (2007).
unfair fines,” the Centers for Medicare and Medicaid Services (CMS), another agency of the HHS’s, created several amendments to the EMTALA regulations, which became effective in 2003. The amendments:

[Reiterate and clarify] changes regarding emergency patients presenting to off-campus clinics that do not routinely provide emergency services, the applicability of the EMTALA provisions to hospital inpatients and outpatients, the circumstances under which physicians must serve on hospital medical staff “on-call” lists, and the responsibilities of hospital-owned ambulances.

Despite its challenges, government agencies strive to make EMTALA work better. Thomas A Scully, the Administrator of Centers for Medicare & Medicaid Services (CMS) since 2001, stated, “[w]e’ve methodically tried to go through the statute and find ways to rationalize and straighten up EMTALA . . . [and] suggest ways to apply EMTALA in a ‘real world’ context.” Even with the constant refinements to make EMTALA work better, “CMS attempted to stay true to Congress’ original intent of avoiding patient dumping and guaranteeing access to emergency room care[,]” Mr. Scully noted.

IV. REFORM PROPOSALS

A. Abolishing EMTALA: A Bad Idea

Because of these problems with EMTALA, at least one critic has suggested abolishing EMTALA altogether. EMTALA is important, however, for several reasons. First, at common law, physicians do not have a duty to treat a patient absent a physician-patient relationship. If doctors will not voluntarily treat patients knowing that they will not be compensated, either charity or the government will have to make

78. Id. at 1033.
80. Schaffner, supra note 11, at 1034.
81. Schaffner, supra note 11, at 1033.
82. Id.
83. See David A. Hyman, Consumer Protection in a Managed Care World: Should Consumers Call 911?, 43 VILL. L. REV. 409, n.122 (1998) (“The obvious solution . . . is to repeal EMTALA insofar as it applies to the insured, and allow ED coverage to seek its own level.”).
84. Bera, supra note 9, at 621.
sure that patients who have no insurance receive emergency medical care.\textsuperscript{85}

Second, EMTALA is necessary because it has traditionally been difficult for a plaintiff to sue hospitals for malpractice under medical malpractice or other negligence theories.\textsuperscript{86} This is because hospitals, as distinct entities, do not owe a duty of care directly to patients.\textsuperscript{87} Hospitals may be found liable under the theories of respondeat superior or negligent hiring, but they “have been highly successful in avoiding liability by invoking charitable and governmental immunity and by persuading courts that doctors are independent contractors and not agents of the hospital.”\textsuperscript{88} But for EMTALA, hospitals would have no obligation to treat anyone, and patients who were refused treatment or given inferior treatment because of their inability to pay would have little recourse against the hospitals, at least in some jurisdictions.\textsuperscript{89}

In essence, if used properly, “EMTALA has the potential to become an effective means of ensuring that each person receives adequate emergency medical care as and when needed.”\textsuperscript{90} The good thing about EMTALA is that it serves to “hold providers to an acceptable minimum standard in making available quality emergency care.”\textsuperscript{91} Hospitals are inclined to comply with EMTALA because they fear that they will be investigated and may be fined.\textsuperscript{92}

\textit{B. Allowing a Private Cause of Action Against Physicians: Another Bad Idea}

\textit{1. Discussion of Proposal}

A recent Comment by Lawrence Bluestone proposes that EMTALA be made more effective by allowing a private cause of action against physicians.\textsuperscript{93} Presently, the text of EMTALA is silent regarding a private right of action against physicians.\textsuperscript{94} The legislative history,
however, clearly states the intent that there should be no private right of action against physicians:95

[T]he Committee amendment makes it clear that the section authorizes only two types of actions for damages. The first of these could be brought by the individual patient who suffers harm as a direct result of a hospital’s failure to appropriately screen and stabilize, or properly transfer the patient . . . (within the meaning of [the Act]) or a woman in active labor. It also clarifies that actions for damages may be brought only against the hospital which has violated the requirements of [the Act].96

Congress’ main goals in enacting EMTALA were (i) to avoid patient dumping,97 and (ii) to avoid burdening the medical community excessively.98 One type of excessive burden Congress particularly sought to avoid is the federal malpractice action, which would burden not only the medical community but also the courts.99

The problem, according to Bluestone, is that the decision-makers in hospitals are the physicians, and without risking personal liability, they have insufficient incentives to refrain from dumping patients. Hospitals have an incentive under EMTALA to prevent dumping, and this gives physicians an indirect incentive in that they work for hospitals. However, the hospitals’ incentives are mixed: EMTALA gives them a disincentive to dump, but the desire to reduce costs is an incentive to dump.101

Bluestone proposes that the federal courts therefore recognize a private right of action under EMTALA against a physician for intentional dumping.102 Such a private right of action would give physicians a real incentive to refrain from dumping.103 This private right of action, he argues, would be more limited than a federal medical malpractice action104 because it would not allow a patient to sue a doctor for mere negligence.105 Claims that allege negligence instead of an intentional failure to treat would be thrown out for failure to state a

95. Id. at 2846–47.
96. Id. at 2847.
97. Id.
98. Id.
99. Bluestone, supra note 41, at 2847.
100. Id. at 2858.
101. Id.
102. Id.
103. Id.
104. See Liang, supra note 5, at 208 (distinguishing EMTALA and medical malpractice as distinct legal concepts and causes of action).
claim. The case was dismissed because the plaintiff attempted to raise an issue of negligent treatment (which should have been brought as a state malpractice claim) under the anti patient dumping statute. In this case, plaintiffs took their fourteen-year-old son, Ted, to the emergency room at Merrithew Memorial Hospital because Ted had “complained of fever, sore throat, headache, chills,” and had a body temperature of approximately 104 degrees. The doctor who examined Ted diagnosed him with influenza, and discharged him with instructions to return if his condition worsened. Four days later Ted’s parents brought him back to the same emergency room, where he was diagnosed with “a common strep infection that had progressed from his sinuses and had entered his brain.” Ted went into a coma and died seven days later.

The plaintiffs brought an action in federal court under EMTALA, with pendent state law claims, alleging that “defendants’ initial misdiagnosis of Ted led them to fail to administer antibiotics that would have remedied the fatal strep infection.” The court dismissed the claim, finding that although failure to stabilize a patient with an emergency medical condition is actionable under EMTALA, negligently failing to recognize an emergency medical condition is not.

A limited private right of action, Bluestone argues, supports the main goal of EMTALA. Moreover, it is consistent with the plain language of the statute and possibly consistent with congressional intent. To date, a majority of courts have rejected this private right of action. A minority of this majority reached this conclusion by observing that the statute is silent regarding the private right of action.

106. See id. at 2859.
108. Id.
109. Id.
110. Id. at 2.
111. Id.
112. Id.
114. Id.; see also Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1039 (D.C. Cir. 1991) (finding that “[EMTALA] does not create a broad federal cause of action for emergency room negligence or malpractice.”).
115. Bluestone, supra note 41, at 2858.
116. Id.
117. Id. at 2843.
against physicians but expressly establishes a private right of action against hospitals; *expressio unius est exclusio alterius*, thus implies that the former is not permitted.\footnote{118 Id.} The remainder of the majority has read the legislative history to bar a private right of action against physicians.\footnote{119 Id. at 2843–47.} If the legislative history is read to mean only that Congress wanted to bar a private right of action for medical malpractice, then this narrower private right of action, for intentional dumping only, may be consistent with congressional intent.\footnote{120 Id.} In any event, argues Bluestone, even if there is a conflict between the primary goal of the statute—to prevent dumping—and the legislative history (which militates against inferring this private right of action), the former should prevail when courts interpret EMTALA, and courts should therefore allow this new private right of action.\footnote{121 Bluestone, supra note 41, at 2843–47.}

### 2. Proposal’s Weaknesses

A proposal favoring a private right of action is flawed, however. As Bluestone acknowledges, a hospital is a more desirable defendant than a physician is because it has deeper pockets,\footnote{122 Id. at 2864.} and plaintiffs are unlikely to avail themselves of the new private right of action even if most courts begin to recognize it. Moreover, if dumping is indeed too frequent, there are other, equally or more effective means of controlling it. Fines could be increased and strictly enforced, and the Office of the Inspector General, could be more vigilant. Hospitals may not be the decision-makers in individual cases, but they set policies, and if a hospital institutes a strict no dumping policy, its physicians will be only too happy to comply. Physicians, after all, would prefer to cure patients, and will be tempted to dump them only if the hospital provides incentives to do so.

### C. Tax Benefits to Assist Doctors: A Good Idea

Establishing more causes of action for injured patients will not increase the effectiveness of EMTALA: financial assistance must be supplied. This assistance should come in the form of tax benefits for hospitals and physicians and in the form of financial support to encourage hospitals to establish preventive care programs.

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\footnote{118 Id.} \footnote{119 Id. at 2843–47.} \footnote{120 Id.} \footnote{121 Bluestone, supra note 41, at 2843–47.} \footnote{122 Id. at 2864.}
Representatives introduced two recent bills in the House this year: The Mitigating the Impact of Uncompensated Service and Time Act of 2007 (MUST Act)\textsuperscript{123} and the Treat Physicians Fairly Act.\textsuperscript{124} These Acts would not affect salaried physicians (who are paid the same amount regardless of a patient’s insurance coverage or ability to pay), but they would benefit privately contracted emergency physicians who are paid only when their patients, or their patients’ insurance companies, pay. Not for profit hospitals would be unaffected by both Acts, as they do not pay taxes, but for-profit hospitals would benefit, especially in cases where the treating physicians are salaried.

The MUST Act proposes to amend the Internal Revenue Code to allow doctors a bad debt deduction, equal to the amount of the Medicare fee schedule payment.\textsuperscript{125} This deduction would partially offset the cost of providing uncompensated care.\textsuperscript{126} This proposal attempts to alleviate the financial burden on physicians because they themselves are not being compensated for their services. The expenses associated with providing EMTALA care—drugs administered to patients, for example—are deductible expenses, but not the value (or opportunity cost) of the physician’s time. Therefore, allowing a bad debt deduction equal to the amount of the Medicare fee schedule payment will benefit physicians because the value of their time is a component of the estimated cost on which the Medicare fee payment schedule is based.

The Treat Physicians Fairly Act, on the other hand, seeks to provide tax credits to physicians to compensate them for the costs of providing uncompensated care.\textsuperscript{127} Although this act provides no further details regarding the proposed treatment of the credits, this act, like the MUST Act, essentially seeks to “alleviate the financial burden of physicians who are required to provide emergency care required under EMTALA.”\textsuperscript{128} A statement made by the Honorable Ron Paul, in proposing the Treat Physicians Fairly Act reads:

EMTALA could actually decrease the care available for low-income Americans at emergency rooms. This is because EMTALA discourages physicians from offering any emergency care. Many physicians in my district have told me that they are

\textsuperscript{123} The Mitigating the Impact of Uncompensated Service and Time Act of 2007, H.R. 1233, 110\textsuperscript{th} Cong. (2007) [hereinafter Mitigating the Impact].
\textsuperscript{125} Mitigating the Impact, supra note 123, at 20.
\textsuperscript{126} Id.
\textsuperscript{127} Treat Physicians Fairly Act, supra note 124.
\textsuperscript{128} Id.
considering curtailing their practices, in part because of the costs associated with the EMTALA mandates. Many other physicians are even counseling younger people against entering the medical profession because of the way the Federal Government treats medical professionals. The tax credits created in the Treat Physicians Fairly Act will help mitigate some of the burden government policies place on physicians.129

“The Treat Physicians Fairly Act does not remove any of EMTALA’s mandates; it simply provides that physicians can receive a tax credit for the costs of providing uncompensated care.”130 The Honorable Ron Paul claims that “by providing some compensation in the form of tax credits, this Act helps remove the disincentives to remaining active in the medical profession built into the current EMTALA law.”131 While the MUST Act reduces medical professionals’ taxable income, the Treat Physicians Fairly Act provides for a tax credit that reduces the amount of tax owed dollar for dollar.

1. Criticism

a. A Compromise

The two bills, although fundamentally logical, are arguably arbitrary. Any approach to physician compensation will fall between two extremes: requiring the doctor to bear the full cost of treating those patients, and having the government reimburse the doctor in the full amount the doctor would have received had the patient been covered by medical insurance. In the first extreme, the government has no expense; in the second extreme, the doctor is made entirely whole. Each of the Acts above proposes a compromise between the two extremes. In its current form, EMTALA is already a solution between the two extremes – taxpayers pay for part of the physician’s expenses in the form of a deduction that she takes for those expenses. The physician is not compensated for her time, however, nor for that portion of her expenses for which she is not reimbursed by the tax benefit. However, it is merely a compromise between the two extremes, and it is not obvious that this is the optimum level of reimbursement. This law may further complicate the already complicated tax law. A simpler alternative may be for the government to provide direct partial reimbursement for EMTALA patients.

129. Id.
130. Id.
131. Id.
b. Tax Loss to the Treasury

Both acts will also cost the U.S. treasury a reduction in tax revenues. According to the American Medical Association’s 2001 Patient Care Physician Survey (PCPS), \(^{132}\) EMTALA related bad debt amounted to $12,300 per self-employed physician in 2000, or nearly 4.2 billion dollars in the aggregate. \(^{133}\) For a marginal tax rate of 35% (a typical corporate federal tax rate), the MUST Act would cost the treasury at least 1.5 billion in tax revenues annually. Because it provides a dollar-for-dollar tax credit, the Treat Physicians Fairly Act would cost the treasury at least 4.2 billion dollars. These figures are lower bounds because they do not include tax revenue losses from for-profit hospitals.

c. Potential Abuses

If either the MUST Act or the Treat Physicians Fairly Act is enacted, special auditing measures will need to be instituted to prevent physicians from claiming tax benefits to which they are not entitled. Absent such provisions, a physician might be tempted to reduce her taxable income dramatically by claiming that she had treated a larger number of EMTALA patients than she had. This temptation might be particularly difficult for physicians to resist; physicians are highly compensated (2007 average annual general surgeon salary was $292,104) \(^{134}\) and as a result have high marginal tax rates. Moreover, physicians are trained to be creative and analytical and are easily capable of devising such means to reduce their taxes.

One way to make it more difficult for physicians to claim unjustified tax benefits is to require hospitals to make patient lists available to IRS auditors on request, and to require each physician to keep records identifying each individual to whom uncompensated care was provided under EMTALA. This record keeping would be mandatory under the tax code and an IRS auditor would be able to review these records during an audit. An auditor who suspected a physician of fabricating her records could then simply verify the physician’s records against the hospital’s.

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132. See Kane, supra note 53 (“The PCPS is a nationally representative survey of post-residency, non-federal, patient care physicians that is conducted via mail and phone interviews.”).
133. Id.
D. Financial Support to Encourage Preventive Care via Urgent Care Centers: A Good Idea

In some situations, relatively inexpensive preventive care can save a hospital a considerable portion of the costs it might otherwise incur under EMTALA. Because EMTALA provides free emergency care for some uninsured patients, these patients may wait until they have an emergency medical condition before seeking treatment. This needlessly increases the cost of treatment, both because preventing a problem is often less costly than treating it, and because emergency treatment is particularly expensive.

Unable to afford health insurance, Dee Dee Dodd had for years been mixing occasional doctor visits with clumsy efforts to self-manage her insulin-dependent diabetes, getting sicker all the while. In one 18-month period, Ms. Dodd, 38, was rushed almost monthly to the emergency room, spent weeks in the intensive care unit and accumulated more than $191,000 in unpaid bills. That is when nurses at the Seton Family of Hospitals tagged her as a ‘frequent flier,’ a repeat visitor whose ailments — and expenses — might be curbed with more regular care. The hospital began offering her free primary care through its charity program. With patients like Ms. Dodd, ‘they can have better care and we can reduce the costs for the hospital,’ said Dr. Melissa Smith, medical director of three community health centers . . . that use its profits and donations to provide nearly free care to 5,000 of the working poor. Over the last 18 months, Ms. Dodd’s health has improved, and her medical bills have been cut nearly in half . . . ‘For most preventive efforts there is an upfront expense,’ said Alan D. Aviles, president of the corporation. ‘But over the long term it saves money.’ . . . Officials [have] calculat[ed] that for every dollar they spend on prenatal care for uninsured women, they save more than $7 in newborn and child care . . . .

To encourage solutions of this kind, Congress should provide financial support or other assistance such as tax benefits to hospitals that open urgent care centers near their emergency departments and offer free preventive care at those urgent care centers.

Indeed, a significant incentive is necessary if hospitals are to provide preventive care for any patients other than those who are

136. Lee, supra note 71, at 166.
chronically ill and frequent visitors to their emergency rooms. Unless most of the hospitals in a given region are providing similar care, any hospital known to provide free preventive care risks becoming a magnet for a large group of local uninsured patients. This does not mean that Congress would have to fund the entire cost of the preventive care programs, however; a tax benefit that reduces the residual cost of preventive care below the alternative cost of emergency care may be sufficient to make it beneficial for hospitals to offer preventive care.

V. CONCLUSION

EMTALA is helping to alleviate the problem of patient dumping, but it has not succeeded at eradicating the problem. Allowing other causes of action such as a private cause of action against physicians—suggested in a proposal—is unnecessary and would be ineffective: doctors already have adequate incentives to comply with EMTALA.

But hospitals’ incentives are mixed. Hospitals desire to avoid EMTALA sanctions, and to treat every patient humanely, but each patient a hospital treats under EMTALA reduces its profits. Moreover, patients who are aware of their right to a medical screening exam under EMTALA may abuse this right by demanding to be seen for non-emergency medical problems. This burdens emergency departments with cases that could be treated more effective and at lower cost in non-emergency clinics.

To better effectuate its intent, Congress should provide financial support or other means such as tax benefits to reduce the burden of complying with EMTALA. Such support would help to address both problems. Indigent patients given proper preventive care would need emergency care less frequently, reducing the cost to hospitals of complying with EMTALA. And, indigent patients would not get a mere screening examination, but effective preventive care.

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