The Emergency Medical Treatment and Labor Act as a Federal Health Care Safety Net Program

W. WESLEY FIELDS, MD, BRENT R. ASPLIN, MD, MPH, GREGORY L. LARKIN, MD, MSPH, CATHERINE A. MARCO, MD, LOREN A. JOHNSON, MD, CHARLOTTE YEH, MD, KEITH T. GHEZZI, MD, MICHAEL RAPP, MD

Abstract. Despite the greatest economic expansion in history during the 1990s, the number of uninsured U.S. residents surpassed 44 million in 1998. Although this number declined for the first time in recent years in 1999, to 42.6 million, the current economic slowdown threatens once again to increase the ranks of the uninsured. Many uninsured patients use hospital emergency departments as a vital portal of entry into an access-impoverished health care system. In 1986, Congress mandated access to emergency care when it passed the Emergency Medical Treatment and Labor Act (EMTALA). The EMTALA statute has prevented the unethical denial of emergency care based on inability to pay; however, the financial implications of EMTALA have not yet been adequately appreciated or addressed by Congress or the American public. Cuts in payments from public and private payers, as well as increasing demands from a larger uninsured population, have placed unprecedented financial strains on safety net providers. This paper reviews the financial implications of EMTALA, illustrating how the statute has evolved into a federal health care safety net program. Future actions are proposed, including the pressing need for greater public safety net funding and additional actions to preserve health care access for vulnerable populations. **Key words:** Emergency Medical Treatment and Labor Act; safety net; health insurance; funding. ACADEMIC EMERGENCY MEDICINE 2001; 8:1064–1069

FOR several decades, the U.S. Department of Health and Human Services has promoted health care access by emphasizing the importance of having health insurance and a regular source of continuing care.[1] Yet because public and private efforts to achieve universal access to health care insurance and to promote affordable and convenient points of service have been unsuccessful, an unfunded mandate on hospital-based providers has emerged as the most important and least recognized federal health care safety net program. As enacted by Congress in 1986, enforced by the Centers for Medicare and Medicaid Services (CMS), and recently upheld by the U.S. Supreme Court,[2] the Emergency Medical Treatment and Labor Act (EMTALA) is a civil right extended to all U.S. residents.[3] This federal law requires screening and stabilization for all who seek emergency department (ED) care, regardless of ability to pay, and it threatens both physicians and hospitals with explicit legal and financial penalties for noncompliance. Hospitals with EDs, emergency physicians (EPs), and the medical and surgical specialists who back them up are providers of the first health care service to be legally identified by the federal government as an essential public service.

The Institute of Medicine (IOM) recently noted several threats to the future viability of the health care safety net, including inadequate funding, poor integration of services, increased price competition in the health care marketplace, and rapid growth in Medicaid managed care.[4] The IOM defined "core safety net providers" as having 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.

The U.S. emergency medical care system continues to operate on the basis of universal access to care for all who seek it, and EDs play a vital role as core safety net providers in today's health care system. As mandated by EMTALA, emergency

From the American College of Emergency Physicians Safety Net Task Force (WWF); Regions Hospital and HealthPartners Research Foundation, St. Paul, MN (BRA); Guy's & St. Thomas' NHS Trust, London, UK (GLL); St. Vincent Mercy Medical Center, Toledo, OH (CAM); Sutter Medical Center, Davis, CA (LAJ); American College of Emergency Physicians Task Force on Health and the Uninsured (CY); American College of Emergency Physicians Federal Government Affairs Committee (KTG); and American College of Emergency Physicians.
Received February 26, 2001; revision received July 17, 2001; accepted July 31, 2001.
Address for correspondence and reprints: W. Wesley Fields, MD, 24411 Health Center Drive, Suite 385, Laguna Hills, CA 92653. Fax: 949-951-6673; e-mail: fieldsw@medamerica.com

services are uniformly available to all, regardless of age, race, gender, religion, insurance status, or time of day. In practice, EMTALA is far more than a legal requirement for providers to perform emergency medical screening for ED outpatients. Because of the legal and ethical obligations of physicians and hospitals to stabilize life- and limb-threatening medical conditions, EMTALA in effect guarantees definitive hospital care for catastrophic illness or injury to all U.S. residents. The EMTALA statute protects 42.6 million uninsured individuals, as well as those who are enrolled in private or government-sponsored insurance plans.[5] In this respect, it rivals all other federal health care programs in both scope and influence. In an era of fragmented delivery systems and growing numbers of uninsured U.S. residents, EMTALA has profound implications for access to medical care. This paper reviews the financial implications of EMTALA, illustrating how the statute has evolved into a federal health care safety net program.

EMTALA as a Health Care Delivery Mandate

Although the IOM report did not explicitly list them as core safety net providers, the nation's 5,000 EDs have emerged as perhaps the most visible safety net facilities in the current health care environment. The importance of EMTALA-mandated access to basic health care is underscored by the fact that there are only 1,000 federally chartered nonprofit clinics.[5] Although most safety nets are by nature local or regional in structure, the American Hospital Association's (AHA's) annual survey demonstrates the vast size and national scope of the EMTALA safety net.[6] For the 5,229 nonfederal acute care hospitals reporting in 1994, hospitals were sorted by the percentage of uncompensated care provided.[7] The top decile reported that 15% of total operating revenue was uncompensated care. This decile was more than twice as likely to contain public or district hospitals (50% vs 22% for all other deciles) and also included most of the major teaching facilities in the nation, yet only 55% of these hospitals were within metropolitan statistical areas. Thus, nearly half the hospitals in the top decile of uncompensated care were rural facilities, many with fewer than 50 beds. For the other nine deciles of safety net facilities, which provided approximately 60–70% of all uncompensated care in 1994, the overall picture is different. Seventy-seven percent were private community facilities (the vast majority had nonprofit status), 80% did not have resident physicians to provide professional services to the uninsured, and 82% were outside of the nation's 100 largest cities.

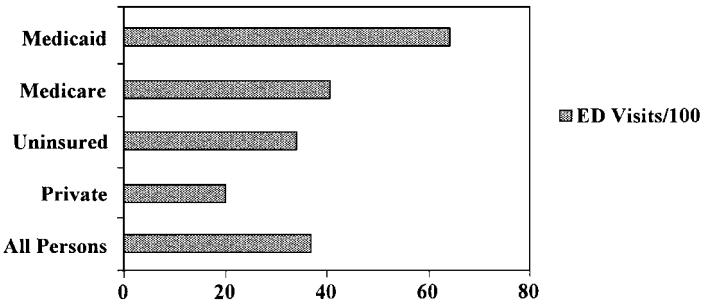

Figure 1. Estimated emergency department (ED) visits per 100 individuals by insurance type. The overall mean was 37.3 visits per 100 residents. Uninsured individuals had 34.2 and privately insured people had 19.9 visits per hundred. Medicaid beneficiaries had the highest utilization rate (64.2). From National Center for Health Statistics/Census Bureau 1998 data.

The National Center for Health Statistics (NCHS) estimated that 100.4 million ED visits occurred in the United States in 1998, including 15.1% by patients who were self-pay.[8] Although NCHS staff equate the uninsured with self-pay patients in their surveys, this approach somewhat understates the number of ED patients without insurance, since many states mandate that EDs not charge patients who are medically indigent yet not covered by Medicaid. The NCHS data suggest that 1.2 million no-charge visits occurred in 1998. Taken together, ED visits by the uninsured were approximately 16.3 million in 1998. Census Bureau data for 1998 also estimated that 16.3% of the U.S. population was uninsured.[9] While it is commonly assumed that the uninsured frequent EDs much more than other payer classes, the Census Bureau and NCHS data do not support this notion. For 1998, the NCHS estimated the annual ED visit rate for all persons to be 37.3 per hundred U.S. residents. By applying Census Bureau data on the numbers of U.S. residents without insurance for 1998 to the number of self-pay ED visits in NCHS data, the annual ED utilization rate can be estimated to be 34.2 per hundred. If the same analysis is applied to other payer classes for the same year, the uninsured appear to use EDs more than persons with private insurance (19.9/100), who have better access to non-ED care, slightly less than all U.S. residents, and barely half the rate of Medicaid beneficiaries (64.2/100) (Fig. 1).

In 1997, the American College of Emergency Physicians prospectively studied the ED staffing of 942 hospitals randomly selected from the 1995 database of the AHA.[10] The study concluded that 3,889 full-time equivalents (FTEs) were required to provide treatment for the 18.7 million patients seen in the 942 sampled EDs during 1997. Using these data to estimate workforce needs, approximately 3,400 EPs were employed full-time to treat

TABLE 1. Emergency Physician and Outpatient Facility Costs for Self-pay and No-charge Patients in 1998*

Emergency physician costs	
Total ED visits by self-pay/no-charge patients	16.3 million
Estimated emergency physician RVU per visit	$63.92
Estimated physician RVU costs	$1,041,896,000
Facility costs	
Total self-pay/no-charge ED patients discharged	15.2 million
Estimated hospital costs per visit	$145.50
Uninsured hospital outpatient ED costs	$2,211,600,000

*Estimates of emergency physician and outpatient facility costs for the 16.3 million self-pay emergency department (ED) patients seen in 1998. Inpatient costs arising from admission or transfer to another facility following ED stabilization are not included. These estimates use a relative value unit (RVU) analysis to adjust emergency physician and facility charges by the Medicare cost-to-charge ratio.

the 16.3 million uninsured ED patients seen in 1998, or 14% of the entire emergency medicine (EM) workforce.

Public data suggest that the total direct expense for EP services to the uninsured is approximately $1 billion annually.[11,12] In 1996, Williams reported a relative value unit (RVU) analysis of EP charges adjusted by Medicare cost-to-charge ratios. The all-patient mean physician staffing cost in this study was $63.92. When extrapolated to the 16.3 million uninsured patients seen in 1998, estimated physician staffing costs were just over $1 billion. Using the same methodology, Williams estimated that mean facility costs for patients discharged from the ED were $145.50. In 1998, 14.1 million self-pay patients in the NCHS survey were discharged from the ED. Total facility costs for these patients were therefore just over $2 billion (Table 1).

The stabilization requirement under EMTALA also applies to inpatients with new or unresolved emergency medical conditions, extending the full costs of the EMTALA mandate far beyond the costs of ED care. The NCHS data for ED visits in 1998 reported 1,048,000 hospitalizations by self-pay patients at the facilities where they initially presented, as well as 315,000 transfers to other facilities. Given the EMTALA prohibitions against transfers for financial reasons alone, it is reasonable to assume that self-pay patients are only transferred to a higher level of hospital care, or to public hospitals with obligations to care for the medically indigent within local safety nets. Taken together, without including 89,000 admissions and 19,000 transfers of no-charge patients, NCHS data suggest that 1,360,000 hospitalizations for self-pay patients directly resulted from ED visits. Remarkably, NCHS data on all hospital discharges in 1998 suggest that self-pay patients were responsible for only 1,469,000 admissions to acute care facilities. Thus it appears that nearly 93% of all U.S. hospitalizations by the uninsured can be directly linked to an ED visit (Fig. 2).

Although the direct facility costs of EMTALA-related hospitalizations are difficult to measure, an estimate can be made from a 1987 analysis by the Agency for Healthcare Research and Quality (AHRQ). In this study the uninsured incurred $5,679 in costs per hospitalization (108% of the average cost for insured patients).[13,14] Thus, without cost adjustments for the period between 1987 and 1995—a period when costs were rising rapidly in many markets—the 1.47 million admissions (including transfers) of self-pay patients from the NCHS survey cost hospitals at least $8.35 billion in 1998.

The Congressional Budget Office's (CBO's) projections regarding uncompensated hospital and physician costs support the role of the ED as the central portal of access for America's uninsured and underinsured. The CBO estimated that in 1991 the uninsured received $15.2 billion in uncompensated hospital care, and predicted that by 1995, the total cost of total uncompensated care would grow to $27.6 billion, with $11.0 billion provided by physicians.[13,15] These losses are not limited to care for the uninsured, since Medicaid reimbursement does not approach provider costs in most states, and managed care organizations (MCOs) are increasingly likely to contribute to uncompensated care. Similarly, it is difficult to estimate the office costs of follow-up services provided by on-call and backup specialists, which may go far beyond those provided in the ED and hospital. Since NCHS survey data suggest that 45.6% of all ED patients were referred to another physician or clinic (nearly four times the number of ED patients admitted to the hospital), it is not unreasonable to assume that the full professional costs of outpatient care for the 14.1 million self-pay ED patients not requiring hospitalization are substantial, and might approach those of patients admitted to the hospital. In any case, EMTALA-related services to self-pay and no-charge patients appear to account for half of all uncompensated hospital costs in 1998.

Regardless of their ability to pay, ED patients already lack timely access to services provided by specialists who back up EPs. Because of growing disenchantment among specialists with the number of uninsured, Medicaid, and non-contracted MCO patients for whom they receive little or no reimbursement for ED services, 60% of California hospital administrators and physician executives recently reported "serious" problems with ED

backup in their facilities.[16] Emergency department crowding, which recently has been widely reported in the mass media, may continue to occur more frequently.[17] This can be traced to narrow or negative operating margins of hospitals, a shortage of acute care nurses, and ED closure rates 27% higher than those for hospitals themselves.[18] These disturbing trends underscore the need for explicit safety net financing to cover the cost of care provided under EMTALA and prevent further disruptions in health care access for vulnerable populations.

Beyond the commitment of hospitals and physicians participating in the safety net, EMTALA has become the federal instrument that affords uninsured patients the same hospital care for life-threatening illnesses and injuries that would be expected if they were insured. This right was at the core of a recent Supreme Court decision, which held that a hospital's obligation to patients admitted via the ED extends until they are stable for discharge home. Unfortunately, the AHRQ analysis suggests that the costs of acute hospital care may be higher for uninsured patients, likely because of delays in seeking care due to inadequate access. The full costs of ED outpatient and hospital inpatient care rendered to the uninsured by safety net facilities and physicians in 1998 can be crudely estimated to be $15–20 billion. This estimate is worthy of statistical validation, given the scale and importance of EMTALA in the continuing health care policy debates.

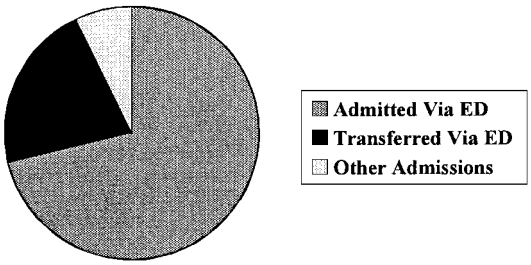

Figure 2. More than 93% of the 1.47 million hospitalized self-pay patients in 1998 were admitted via the emergency department (ED). These data reflect the essential role EDs play in maintaining access to inpatient care for the uninsured. NCHS = National Center for Health Statistics. From: National Center for Health Statistics/ED hospital survey data from 1998.

Directions for the Future

For better or worse, EMTALA has become more important today than when it was first enacted. The statute ensures that hospital EDs have been one of the few sources of stability in an otherwise fraying health care safety net. We applaud the ethical basis for EMTALA, yet question whether its mandates can be maintained given the resource limitations in the health care system following an era of market-driven reform. We must continue to advocate for incremental expansions in health insurance coverage. There are many mechanisms for expanding coverage, and a detailed discussion of these is beyond the scope of this paper; however, the EMTALA funding gap will never be filled if the number of uninsured Americans continues to grow. But barriers to the expansion of insurance coverage, however frustrating, should not eclipse creative strategies for funding EMTALA-mandated care at the local, state, and federal levels.

At the local level, EPs must network more effectively with other core providers in the community to help mend the safety net's fabric in ways heretofore unimagined. For example, sharing patient information, enhancing communication, and creating local networks of safety net providers may improve continuity of care for vulnerable populations. Emergency departments are also part of the solution in the public health paradigm and can be used locally as a prospective surveillance, health risk appraisal, and immunization network. Local stakeholders may support these services if a clear community benefit can be demonstrated. Not-for-profit hospitals may wish to consider the merits of allowing community-based safety net providers access to higher technologies and special services for their patients before acute hospitalizations are required, as MCOs have already done for insured populations.

State policy can demonstrably be influenced when policymakers, hospital and professional associations, and patient advocacy organizations hear the collective voice of EM. These groups can collaborate to generate data that define the scope and cost of EMTALA-related care, and also identify the most efficient mechanisms to allocate resources. National associations in EM must coordinate state-level efforts and serve as clearinghouses for effective solutions and strategies.

Policymakers at CMS and elsewhere in the federal government should consider whether the current mandate on individual hospitals under EMTALA could not more effectively be defined as an obligation of communities and health care systems. This approach would take into account the extensive consolidation of both hospitals and physician groups that has occurred since EMTALA was enacted. Further, it would encourage competing provider organizations within local markets to consider how to cooperatively share the burdens created by EMTALA. Local emergency medical services agencies are already given discretion regarding transfer and destination policies under EMTALA. Broadening participation of local and regional governments and community leaders in de-

cisions about safety net services and resource allocation would appear to support EMTALA's original intent of protecting vulnerable populations. Federal policymakers should also consider using disproportionate share (DSH) payments to support EMTALA-mandated services. Currently, DSH payments are added to Medicare and Medicaid payments for facilities that serve a high proportion of uninsured and Medicaid patients. It may be possible to reform the DSH payment system to include funding for care provided under EMTALA.

CONCLUSIONS

It is increasingly difficult for hospital-based safety net providers to deliver on the EMTALA promise of universal access to ED services in the absence of direct funding for the mandate. Given that the U.S. health care delivery system is increasingly predicated on market-driven pricing of services to separately pooled populations in MCOs, the task grows more impossible by the day. Ultimately, Americans must decide as a democratic society how to resolve the crisis of inadequate access to health care and health insurance. Access to emergency services will be increasingly in jeopardy for all U.S. residents, regardless of their insurance status, if we fail to reconcile the inherent conflict between government mandates on a shrinking pool of hospital-based safety net providers and a health care marketplace still driven by profit. Although EMTALA-related costs do not appear among their principal drivers, overall increases in medical costs and managed care market share have combined to produce a funding vacuum that the safety net cannot hope to fill.

Although at the time EMTALA was passed in 1986, Congress, CMS, and providers could rely on employer-sponsored indemnity programs to cross-subsidize the costs of uncompensated care for the uninsured and underinsured; that is no longer the case. To the extent that MCOs operate at arm's length from the mandates and missions of safety net providers, there is little reason to expect them to consider the true costs of care for the underinsured in their contracts with such facilities, or their professional staffs. Although EMTALA is one of the only rights to health care in U.S. law, there are no accompanying requirements for payers, public or private, to support such a mandate. Actuaries at CMS have predicted that within ten years, health care expenditures will double because of demand for services among the better insured.[19] Like the providers of other essential public services, hospital and community-based care providers must recover their costs in order to maintain access to services. Policymakers must consider the implications of EMTALA for the health care safety net, and act quickly to support the essential services that EMTALA guarantees for all.

With the decline in Hill-Burton funds, the closure of public and private hospital EDs, MCO gatekeeping, and the growing strata of uninsured, ED access is at a 20-year low.[20] The *need* for ED access, however, has never been greater: interpersonal violence, illegal immigration, drug and alcohol addiction, mental illness, the rise in asthma-related mortality, and other acute illnesses all demand ready access to safety net providers.[21,22] If America continues to take the EMTALA-based system for granted, increasing numbers of patients will fall through the ever-widening holes in the health care safety net. The old economics, which treats health care as a commodity, must give way to a new order, which affirms that safety net care in general, and emergency care in particular, constitutes an essential public service worthy of protection.

References

1. Simpson G, Bloom B, Cohen RA, et al. Access to Health Care Part 1: Children, Vital and Health Statistics, Series 10 [National Health Survey No. 196]. Huntsville, MD: National Center for Health Statistics, 1997.
2. The Supreme Court makes it easier to sue hospitals for dumping patients in need of emergency care. Associated Press via NewsEdge Corporation. Washington, DC, Jan 14, 1999.
3. Health Care Financing Administration. The Emergency Medical Treatment and Active Labor Act, as established under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 USC 1395 dd). Federal Register. 1994; 59:32086–127.
4. Lewin ME, Altman S (eds). America's Health Care Safety Net: Intact but Endangered. Institute of Medicine. Washington, DC: National Academy of Science Press, 2000.
5. Mills RF. Health Insurance Coverage 1999. Current Population Reports. Washington, DC: U.S. Census Bureau, 2000.
6. American Hospital Association. Hospital Statistics 97/98: Emerging trends in hospitals. Washington, DC: American Hospital Association, 1998.
7. Fishman LE. What types of hospitals form the safety net? Health Aff. 1997; 16:215–22.
8. McCaig LF. National Hospital Ambulatory Medical Care Survey: 1998 Emergency Department Summary. Hyattsville, MD: National Center for Health Statistics, 2000.
9. Campbell JA. Health Insurance Coverage: 1998. Current Population Reports, U.S. Census Bureau, 1999, pp. 60–208.
10. Moorhead JC, Gallery ME, Mannle T, et al. A study of the workforce in emergency medicine. Ann Emerg Med. 1998; 31: 595–607.
11. Fields WW (ed). Defending America's Safety Net. Dallas, TX: American College of Emergency Physicians Safety Net Task Force, 1999.
12. Williams RM. The costs of visits to emergency departments. N Engl J Med. 1996; 334:642–6.
13. Matthews M Jr, Goodman JC. Myths about the Health Care System: Lessons for Policy Makers. Policy Backgrounder #136. Washington, DC: National Center for Policy Analysis, May 11, 1995.
14. Hahn B, Lefkorartz D. Annual Expenses and Sources of Payments for Health Care Services. AHCPR Pub. No. 93-0007, National Medical Expenditure Survey Reserch Findings 14. Rockville, MD: Agency for Health Care Policy and Research, Nov 1992.
15. Robbins G, Robbins A. Projections for 1995, based on: Christensen S. CBO Staff Memorandum: Single Payer and All Payer Health Care Insurance Systems Using Medicare's Payment Rates. Washington, DC: Congressional Budget Office,

Apr 1993.
16. Johnson LA. Results of the on-call backup survey, searching for solutions to a serious public health problem. Lifeline. Manhattan Beach, CA: California Chapter, American College of Emergency Physicians, 1999.
17. Derlet RW, Richards JR, Kravitz RL. Frequent overcrowding in U.S. emergency departments. Acad Emerg Med. 2001; 8:151–5.
18. Fields WW. ED diversions are a troubling trend. ACEP News. 2000 19(8):3.
19. Fubini S. Health spending projections 2000 and beyond. Healthcare Trends Rep. 1999; 13(7):1–15.
20. Weissman J. Uncompensated hospital care: will it be there when we need it? JAMA. 1996; 276:823–8.
21. Larkin GL, Weber J, Derse A. Universal emergency access under managed care: universal doubt or mission impossible? Camb Q Healthc Ethics. 1999; 8:213–25.
22. Larkin GL, Marco CA, Fields WW. Charity care and uncompensated care: the role of emergency physicians in serving the uninsured. JAMA. 1999; 282:1619–20.