I. Background

A. The Problem of Patient Dumping

“Patient dumping” has been defined as “hospital emergency rooms refusing to treat or transferring indigent patients to public hospitals without first assessing and/or stabilizing the patient’s condition.”

“The act of patient dumping occurs when patients [who seek care] in an emergency department are denied emergency medical care or stabilizing treatment based on economic or noneconomic grounds, such as race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease.” In the early 1980s, the news media reported some sensational, horrific stories of patient dumping:

- A pregnant patient was turned aside from an emergency room without examination, gave birth to her baby in the parking lot, and was denied postnatal care when she tried to return to the emergency room following the birth.
- A man with head trauma from a fight died without regaining consciousness after neurosurgeons in a private hospital refused to see him and instead transferred him to a public hospital because he was uninsured.

A private hospital sent a woman in mid-labor to a public hospital for a Cesarean section when she could not pay “cash up front” for the procedure.\(^5\)

A hospital with a burn unit declined to admit an uninsured man with burns over 40 percent of his body.\(^6\)

A man with a knife wedged against his spine was transferred out of an emergency room when he could not pay $1,000 in advance for the hospital to remove the knife.\(^7\)

A man brought to a hospital by ambulance with shortness of breath and in a diabetic coma was taken from his hospital room by the hospital administrator and left in the parking lot after the hospital discovered that he had a large unpaid bill. His friends took him home and he died the next day.\(^8\)

In addition to such anecdotes, many of which are cited in the Congressional hearing reports on patient dumping, research studies such as the 1986 Cook County Study indicated that transfers to public hospitals were primarily due to economic reasons.\(^9\) Hospitals reportedly engaged in practices such as putting yellow stickers on charts of uninsured patients as a reminder to avoid admitting those patients.\(^10\)

One explanation for the apparent increase in patient dumping was the rise of managed health care and the inability of hospitals to shift the costs of indigent care. Hospitals faced new cost-containment pressures, combined with growing numbers of uninsured and

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5. Id., n.2.
6. Id., n.3.
7. Id., n.4.
9. Treiger, *supra* note 4, citing Schiff, Ansell, Schlosser, Idris, Morrison & Whitman, *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 New Eng. J. Med. 552, 556 (1986) (Cook County Study) (concluding that transfers of patients to Chicago’s Cook County Hospital from other hospitals’ emergency rooms were predominantly for economic reasons).
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underinsured patients. The increase in managed healthcare [made] it increasingly difficult to shift costs to payers who are unwilling to pay the added expense of the uninsured. As cost shifting becomes more difficult, providers are not compensated for much of the care they provide to the poor. For uninsured patients, [emergency departments provide a healthcare safety net] because there is nowhere else those patients can turn for care.

B. Previous Attempts to Address Access to Emergency Care

Because the majority of states did not recognize a common-law duty to treat, in the aftermath of the Great Depression and World War II, Congress attempted to ensure and expand access to emergency care through the Hill-Burton Act (Hill-Burton). Hill-Burton provided a series of grants-in-aid “to assist the several States in the carrying out of their programs for the construction and modernization of such public or other non-profit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to all their people.” Hill-Burton further provided that:

[T]he State plan shall provide for adequate hospitals, and other facilities . . . for all persons residing in the State, and adequate hospitals (and other such facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also

14. Id.
require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that...there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefore.\textsuperscript{17}

Unfortunately, Hill-Burton failed to expand the provision of emergency medical services for indigent patients for several reasons:

1. Hospitals in states that chose not to participate in the program were not bound by the mandate to provide care (by 1986, slightly more than half of the states participated);
2. The language of the statute was ambiguous, and hospitals generally ignored the requirement to perform general community services;
3. States were not required to monitor compliance and the Department of Health and Human Services was ineffective in enforcing the Act.\textsuperscript{18}

In 1975, Congress replaced Hill-Burton with Title XVI of the Public Health Service Act, providing for assurances similar to the Hill-Burton Act but adding enforcement capabilities.\textsuperscript{19} The Title XVI regulations mandated a quantitative annual standard of compliance by requiring uncompensated care equal to the lesser of either 3 percent of a facility’s operating cost for the last fiscal year or 10 percent of all federal assistance received by the facility, adjusted to make allowance for inflation for each year after 1979. The regulations further provided that federally assisted health facilities be made available

\textsuperscript{17} Id. at 172-173, citing 42 U.S.C. § 291c(e).
\textsuperscript{18} Charlotte Fillenwarth, Beyond the Emergency Room Doors: Rejecting Patient Admission as Satisfaction of Hospital Obligations Under EMTALA, 11 Ind. Health L. Rev. 791, 796-797 (2014).
\textsuperscript{19} Supra note 17 at 173, citing 42 U.S.C. §§ 300q et seq.
Background to all residents and prohibited a hospital from excluding anyone in its service area on the basis of any factor unrelated to the resident’s need for hospital services.\textsuperscript{20}

\section*{C. Passage of EMTALA}
To address the perceived problem of patient dumping, Representative Fortney “Pete” Stark (D-CA) and Senator Edward Kennedy (D-MA) introduced companion bills in the House and Senate that eventually became the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). The legislative history demonstrates Congress’s intent in enacting EMTALA:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital. The committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.\textsuperscript{21}

As the Sixth Circuit stated:

\begin{quote}
It is undisputed that the impetus to this legislation came from highly publicized incidents where hospital emergency rooms
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\textsuperscript{20} Supra note 17 at 174, citing 42 C.F.R. § 124.503(a) and 42 C.F.R. § 124.603(a)(1).
allegedly, based only on a patient’s financial inadequacy, failed to provide a medical screening that would have been provided a paying patient, or transferred or discharged a patient without taking steps that would have been taken for a paying patient. Apparently dissatisfied with the effect of laws that had been limited to hospitals that received funds from the government under the Hill-Burton Act … Congress chose to attempt to meet the perceived evil by enacting the quoted language.22

However, EMTALA applies to all patients, not only the indigent and uninsured.23 “Because [EMTALA] is clear on its face … the Act applies to any and all patients, not just to patients with insufficient resources.”24 “Congress manifested an intent that all patients be treated fairly when they arrive in the emergency department of a participating hospital and that all patients who need some treatment will get a first response at minimum and will not simply be turned away.”25 EMTALA was not enacted to “guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care, but instead to provide an adequate first response to a medical crisis for all patients and send a clear signal to the hospital community … that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”26

On April 7, 1986, President Reagan signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which included EMTALA in Title IX.27 Hospitals that receive Medicare funds (including virtually every acute-care hospital in the United States) and have dedicated emergency departments have an affirmative duty to

23. Arrington v. Wong, 237 F.3d 1066, 1069-1070 (9th Cir. 2001).
26. Baber v. Hospital Corp. of America, 977 F.2d 872, 880 (4th Cir. 1992) (citations and internal quotations omitted).
screen and (where applicable) stabilize every patient who comes to the emergency department, regardless of ability to pay.

Congressional documents and multiple court decisions interpreting and applying EMTALA refer to the law as being clear on its face. Almost immediately, however, emergency department physicians began to identify and report on ambiguities and problems implementing the Act.28

In 1989 and 1990, Congress addressed some of the ambiguities in the Omnibus Reconciliation Acts of 1989 and 1990.29 The amendments contained in the annual budget revisions provided additional structure and process and included definitions for some of the previously undefined terms. Among the refinements were requirements for each hospital to maintain a list of on-call physicians, and specifics regarding the elements of an appropriate transfer. Congress also modified the standard for imposing civil monetary penalties against hospitals and physicians, as well as for excluding physicians, from a standard of “knowingly” violating the Act, to one of “negligently” failing to meet the requirements.30 To facilitate the changes required to address discriminatory responses to individuals seeking emergency care, Congress inserted mandatory reporting obligations for inappropriate transfer of an unstable patient and whistleblower protections for employees reporting suspected EMTALA violations.

D. The Regulatory Framework; the Technical Advisory Group; and Subregulatory Guidelines

1. The Regulatory Framework
The first set of proposed EMTALA regulations was published jointly by the Health Care Financing Administration (HCFA, now the Centers

28. See, e.g., The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians (2001), Baylor University Medical Center Proceedings 14:339-346 (citing early history with patient dumping postenactment, and problems related to undefined terms and procedural requirements).
29. Omnibus Budget Reconciliation Act of 1989 (OBRA 89) §§ 6003, 6018, and 6021; OBRA 90, §§ 4008(b), 4027(a), and 4027(k)(3).
30. Sections 4008(b)(1) and 4027(a)(2) of OBRA 90.