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The Emergency Medical Treatment and Active Labor Act and Sources of Funding

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*Introduction by Morgan Greenspon**

I. INTRODUCTION

At the Loyola University Chicago School of Law's First Annual Beazley Symposium on Access to Health Care, Dr. Jennifer Cutrer spoke about financial strategies to provide health care to immigrants at Parkland Health and Hospital System ("Parkland"). Dr. Cutrer is the Executive Director of Public Affairs for Parkland, located in Dallas, Texas. As the Executive Director of Public Affairs, Dr. Cutrer reports to the hospital president and CEO regarding the coordination of state, local, and federal legislative policymaking for Parkland. Since Dr. Cutrer is involved in policy matters at a hospital located in a border state, she is uniquely positioned to speak on the issue of access to health care for immigrants, both legal and undocumented.[1] Dr. Cutrer is also an adjunct professor at the University of North Texas-Dallas where she teaches health policy.

Parkland plays a critical role in annually providing health care to hundreds of thousands of patients. Parkland provides care to patients regardless of their ability to pay or their immigration status. Dr. Ron Anderson, Parkland's President, has stated, "[Parkland] decided that these are folks living in our community and [Parkland] needed to render the care."[2]

Safety net hospitals, such as Parkland, provide access to health care for those who lack health insurance and would not otherwise be able to afford medical care. Safety net providers are defined as "institutions and professionals that by mandate or mission deliver a large amount of care to uninsured or other vulnerable populations."[3] The safety net is comprised of

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1. *See generally* Susan Okie, *Immigrants and Health Care- At the Intersection of Two Broken Systems*, 357 NEW ENG. J. MED. 525, 526 (2007) ("[T]he soaring cost of uncompensated care . . . has made the problem of providing care for uninsured immigrants a hot political issue, particularly in border states . . . .").

2. Julia Preston, *Texas Hospitals' Separate Paths Reflect the Debate on Immigration*, N.Y. TIMES, July 18, 2006, at A1.

3. INST. OF MED., AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 21

hospitals that take on substantial responsibility in aiding and serving the uninsured, Medicaid enrollees, and other susceptible populations that face a variety of barriers to accessing health care.[4] The providers that comprise the safety net are an essential component in our current healthcare system, giving care to groups of people who would otherwise be excluded from receiving public benefits.

Safety net providers are not only important to uninsured citizens, but they also play a crucial role in providing health care to undocumented immigrants.[5] While all hospitals that participate in certain federally-funded programs have specific responsibilities regarding what medical services they must provide, hospitals like Parkland have decided to go above and beyond what is federally required. Despite the fear that the provision of public benefits to undocumented aliens will create further incentive for migration,[6] Dr. Cutrer believes that all patients should have health care access because healthcare professionals take an oath to provide care to those in need.[7]

II. TEXAS LAW

Under state law, Texas counties must exercise one of three options to provide health care to their indigent residents: hospital districts, public hospitals, and county indigent health care programs.[8] Regardless of which option a county chooses, there is a "statutory obligation to cover a set of basic healthcare services including primary and preventative services designed to meet the needs of the community."[9] Hospital districts, such as Parkland, are created in accordance with Section 281.002 of the Texas

(Marion Ein Lewin & Stuart Altman eds., 2000), *available at* http://www.nap.edu/openbook.php?isbn=030906497X.

4. JACK A. MEYER, ECON. & SOC. RESEARCH INST., SAFETY NET HOSPITALS: A VITAL RESOURCE FOR THE UNITED STATES 1 (2004), http://www.esresearch.org/publications/NAPH_final.pdf.

5. *See* Okie *supra* note 1, at 528; Marlin W. Burke, *Reexamining Immigration: Is it a Local or National Issue?*, 84 DENV. U. L. REV. 1075, 1079 (2007) ("An undocumented alien is anyone who enters the United States without permission to enter . . . or who enters with permission but overstays the time he or she was allowed to remain in the United States.").

6. ALISON M. SISKIN, CONG. RESEARCH SERV., FEDERAL FUNDING FOR UNAUTHORIZED ALIENS' EMERGENCY MEDICAL EXPENSES 13 (2004), http://opencrs.cdt.org/document/RL31630/2004-10-18%2000:00:00.

7. Jennifer Cutrer, Executive Director of Public Affairs for Parkland Health and Hospital System, Panel Speech at the First Annual Beazley Symposium on Access to Health Care: Solving the Problem of Immigration and Health Care (February 8, 2008) (transcript published in the Summer 2008 Issue of *Annals of Health Law*).

8. CAROL KEETON STRAYHORN, OFFICE OF THE TEX. COMPTROLLER, UNDOCUMENTED IMMIGRANTS IN TEXAS: A FINANCIAL ANALYSIS OF THE IMPACT TO THE STATE BUDGET AND ECONOMY 10 (2006), http://www.window.state.tx.us/specialrpt/undocumented/undocumented.pdf.

9. *Id.*

Health and Safety Code, and are required to furnish medical aid and hospital care to indigent and needy persons residing in the district.[10] Additionally, the Texas Constitution stipulates the creation of hospital districts, "providing that any district so created shall assume full responsibility for providing medical and hospital care for its needy inhabitants."[11]

Under Texas law, hospital districts must treat patients without charge if the patient is unable to pay for medical treatment.[12] In order to finance these uncompensated services, hospital districts are given the power to tax the residents of their counties.[13] Thus, Texans residing in a county with a hospital district pay taxes that directly fund medical services for the uninsured and indigent. Although Section 281.002 of the Texas Health and Safety Code does not explicitly require hospitals to provide uncompensated care to undocumented immigrants, hospital districts must also operate in accordance with federal law.[14]

III. THE EMERGENCY MEDICAL TREATMENT & ACTIVE LABOR ACT

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA") in an attempt to curb patient dumping.[15] Patient dumping is the practice whereby a hospital transfers a patient to another hospital or facility, prior to stabilizing the patient, because of the patient's actual or perceived inability to pay.[16] Congress intended EMTALA "to send a clear signal to the hospital community, public and private alike, 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."[17]

Although EMTALA requires only hospitals that receive Medicare funds to provide emergency medical care to all persons who request it,[18] hospitals must accept federal and state sponsored health insurance

10. TEX. HEALTH & SAFETY CODE ANN. § 281.002 (Vernon 2003).

11. TEX. CONST. art. IX, § 9.

12. Op. Tex. Att'y Gen. No. JC-0394 (2001).

13. STRAYHORN, *supra* note 8, at 10.

14. Kristalee Guerra, *The Policy and Politics of Illegal Immigrant Health Care in Texas*, 3 HOUS. J. HEALTH L. & POL'Y 113, 134 (2002).

15. *See* 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

16. Tiana Mayere Lee, *An ETMALA Primer: The Impact of Changes in the Emergency Medicine Landscape on ETMALA Complaint and Enforcement*, 13 ANNALS HEALTH L. 145, 146 (2004).

17. 131 CONG. REC. S13892-01, *supra* note 15.

18. 42 U.S.C. § 1395dd(a) (2000).

programs to maintain financial viability.[19] As a result, EMTALA has become a mandate on every hospital with an emergency department.[20]

Under EMTALA, hospitals have a duty to provide an examination to determine whether an emergency medical condition exists whenever a person comes to an emergency department and requests medical treatment.[21] EMTALA defines an emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention would reasonably be expected to result in placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part . . . ."[22] If a hospital determines an emergency medical condition exists, it must either provide medical treatment to stabilize the patient, or in limited circumstances, transfer the individual to another facility.[23]

EMTALA's requirement that hospitals treat any individual who presents with an emergency condition applies not only to uninsured and indigent Americans, but also extends to undocumented immigrants. Although this ensures that everyone in the United States will receive emergency medical assistance regardless of their financial situation, ETMALA imposes additional challenges for hospitals already dealing with over-strained budgets.

IV. COST OF CARE FOR UNDOCUMENTED ALIENS

Fear of deportation is one of the major factors that influences whether an undocumented immigrant will decide to seek medical care.[24] Thus, a common concern in the safety net community is that undocumented aliens will not seek medical attention until their condition has deteriorated to the point that it becomes a medical emergency.[25] As a result, hospitals are potentially left uncompensated for the emergency care they are required to provide to indigent persons, which is much more expensive than simple preventative care.[26]

EMTALA creates a financial anomaly in which hospitals can only seek federal reimbursement for medical emergencies, and not reimbursement for less expensive preventative care. Perhaps the best illustration of this may

19. Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden it Places on Hospitals*, 7 J.L. SOC'Y 146, 161 (2005).
20. *Id.*
21. 42 U.S.C. § 1395dd(a) (2000).
22. 42 U.S.C. § 1395dd(e) (2000).
23. 42 U.S.C. § 1395dd(b)(1) (2000).
24. Lebedinski, *supra* note 19, at 148.
25. *See* Okie, *supra* note 1, at 526.
26. *See* Lebedinski, *supra* note 19, at 149.

be the costs associated with pregnancy and childbirth. Under EMTALA, a hospital must treat a woman in labor, thereby allowing it to seek reimbursement from Emergency Medicaid for providing this care.[27] However, EMTALA does not include any provisions for prenatal care or family planning.[28] Ironically, under the current system, the federal government will reimburse a hospital for the much higher costs of emergency care, but not for the low costs associated with preventive care; thus, preventing access to primary and preventative care ultimately leads to higher health care costs.[29] Providing early intervention and preventative care would not only make better use of the healthcare system's scarce resources, but it is also medically preferable.[30]

A. Emergency Medicaid

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prevents certain groups of legal immigrants, and all undocumented immigrants, from receiving Medicaid benefits.[31] However, aliens who would otherwise qualify for Medicaid, if not for their immigration status, remain eligible for Emergency Medicaid;[32] these undocumented aliens are entitled to receive emergency services that are necessary for the treatment of an emergency medical condition.[33] Thus, "the current legislation . . . takes a back-end approach by providing illegal immigrants health care access by providing emergency services."[34]

Under Emergency Medicaid, a hospital may be compensated for providing care to undocumented aliens experiencing a medical emergency such as childbirth, labor, or another condition that may threaten an individual's life.[35] However, if the patient does not qualify for Emergency Medicaid, then a hospital may go completely uncompensated.[36] Additionally, if the federal government would help

27. Okie, *supra* note 1, at 526

28. *Id.*

29. *See* Seam Park, *Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change*, 18 GEO. IMMIGR. L.J. 567, 581 (2004) ("[E]mergency treatment can cost nearly 'four to ten times as much' as providing preventative care.").

30. *Id.*

31. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

32. SISKIN, *supra* note 6, at 2-3 ("To be eligible for [E]mergency Medicaid, unauthorized aliens must also be poor and either aged, disabled, or members of a family with children.").

33. *Id.*

34. Park, *supra* note 29, at 581.

35. STRAYHORN, *surpra* note 8, at 6.

36. THE UNITED STATES/MEXICO BORDER COUNTIES COALITION, MEDICAL EMERGENCY:

fund preventative care, there is a good chance the overall amount of money spent on medical care for undocumented aliens would decrease "because it is more expensive to provide emergency care than it is to take a front-end approach by providing preventative care."[37]

B. Medicare Prescription Drug & Modernization Act of 2003

Despite the altruistic intentions of EMTALA, hospitals are obligated to provide care to persons who cannot afford medical treatment and who are not qualified to receive public benefits, thus leaving hospitals without compensation. This has effectively transitioned emergency departments from a place of last resort to "the primary care provider of choice for the nation's uninsured."[38] As a way to offset the financial burden placed on hospitals participating in Medicare, Congress enacted section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") which sets aside $1 billion "in an effort to help hospitals recoup some of their uncompensated expenses."[39] Section 1011 reimburses hospitals for eligible services[40] rendered to undocumented immigrants.[41] Coverage under Section 1011 begins simultaneously with EMTALA obligations.[42] Thus, coverage under Section 1011 commences when an individual presents at the hospital emergency department and requests an examination or treatment for a medical condition.[43] Coverage under Section 1011 continues until the individual is stabilized.[44] In order to be considered stable, a patient's emergency medical condition must be resolved, however, the underlying medical condition may still exist.[45]

Before the MMA, there were no federal funds available to reimburse hospitals for emergency medical services, and hospitals were forced to

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COSTS OF UNCOMPENSATED CARE IN SOUTHWEST BORDER COUNTIES 44 (2002), http://bordercounties.org/vertical/Sites/{B4A0F1FF-7823-4C95-8D7A-F5E400063C73}/uploads/{FAC57FA3-B310-4418-B2E7-B68A89976DC1}.pdf.

37. Park, *supra* note 29, at 581.

38. Laura J. Merisalo, Editor's Corner, 16 No. 8 Healthcare Registration 2 (2007).

39. Press Release, Ctrs. for Medicare & Medicaid Servs., Emergency Health Serv. for Undocumented Aliens: Section 1011 of the Medicare Modernization Act (May 9, 2005), http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1452 [hereinafter Press Release].

40. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, Title X, § 1011, 117 Stat. 2432 (2003) (codified as amended in scattered sections of 42 U.S.C.). ("'[E]ligible services' means health care services required by the application of [EMTALA], and related hospital inpatient and outpatient services and ambulance services . . . .").

41. STRAYHORN, *supra* note 8, at 12.

42. Press Release, *supra* note 39.

43. *See* Lebedinski, *supra* note 19, at 164; Press Release, *supra* note 39.

44. Press Release, *supra* note 39.

45. *Id.*

provide for undocumented, indigent patients.[46] Under Section 1011, $250 million per fiscal years 2005 through 2008 is appropriated specifically to compensate and reimburse hospitals for providing these services.[47] Two-thirds of the Section 1011 funds, or $167 million, is proportionally dispersed to the states based on their relative percentages of the total number of undocumented aliens.[48] The remaining one-third, $83 million, is given to the six states with the largest number of undocumented alien apprehensions for each fiscal year.[49]

C. The State Children's Health Insurance Program

The State Children's Health Insurance Program ("SCHIP") was established in the Balanced Budget Act of 1997.[50] SCHIP was enacted for the purpose of providing funds to aid states in initiating and expanding the provision of child health assistance to uninsured, low-income children.[51]

Given the cost of health insurance, there is a gap between those whom Medicaid will cover and those who can afford independent health insurance.[52] SCHIP was designed to bridge this gap by insuring the children of low-income families who do not qualify for Medicaid.[53] A child qualifies for SCHIP if their family earns up to 200 percent of the federal poverty level,[54] or fifty percentage points higher than the state has previously covered under Medicaid.[55]

Although SCHIP is primarily aimed at covering low-income children, Medicare and Medicaid Services can give waivers to states to use SCHIP funds to cover other groups. In the past, "SCHIP coverage [has been]

46. SISKIN, *supra* note 6, at 11.

47. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, Title X, § 1011, 117 Stat. 2432 (2003) (codified as amended in scattered sections of 42 U.S.C.).

48. Press Release, *supra* note 39.

49. *Id.*

50. COURTNEY M. PERLINO, AM. PUB. HEALTH ASS'N, REAUTHORIZATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP): A KEY STEP TO COVERING ALL KIDS 1 (2007), http://www.apha.org/NR/rdonlyres/F892B8E8-0033-42CE-92E2-A5834E44E4AE/0/SCHIPReauthorizationIssueBrief.pdf.

51. 42 U.S.C. § 1397aa(a) (2000); National Conference of State Legislatures, Forum for State Health Policy leadership, *Frequently Asked Questions. . .SCHIP* 122 (2007), http://www.ncsl.org/print/health/forum/SCHIPFAQ.pdf, [hereinafter Frequently Asked Questions].

52. JEANNE M. LAMBREW, THE COMMONWEALTH FUND, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PAST, PRESENT, AND FUTURE vi (2007), http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf?section=4039.

53. Frequently Asked Questions, *supra* note 51, at 119.

54. Annual Update to the HHS Poverty Guidelines, 73 Fed. Reg. 3971-01 (Jan. 23, 2008) (noting that the federal poverty guideline for a family of four in 2008 is $21,200).

55. Frequently Asked Questions, *supra* note 51, at 121.

extended to include one or more categories of adults with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women."[56]

V. CONCLUSION

America's healthcare safety net providers are currently performing a very delicate balancing act. Physicians and hospitals must abide by federal, local, and professional mandates that require the provision of care to patients regardless of their ability to pay or their immigration status. Additionally, healthcare professionals must also deal with the financial realities of providing such a large amount of potentially uncompensated care. Although the federal government has programs in place to help hospitals offset costs, these programs do not provide reimbursement for all the individuals the hospitals are required to treat with emergency care. Consequently, these financial limitations result in hospitals providing a large amount of uncompensated care.

It is from within this framework that Parkland Health and Hospital System must operate. In the transcript that follows, Dr. Cutrer discusses Parkland and the financial strategies Parkland has undertaken in an effort to meet its responsibilities.

56. *Id.*