

# REEXAMINING THE CIVIL MONEY PENALTIES OF EMTALA AND THEIR EFFECT ON INNER-CITY HOSPITALS

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## INTRODUCTION

Hospitals and medical facilities are often thought of as safe places for everyone, regardless of an individual's race, gender, sexual orientation, or social standing. After all, physicians are required to swear to and abide by the Hippocratic Oath—right? In actuality, physicians are *not* required to swear an oath upon entering the medical profession; and for those that do swear such an oath, the terms are not legally binding.<sup>2</sup> Nevertheless, even if a physician is not bound by words like “first do no harm,”<sup>3</sup> surely a hospital or medical facility is required to uphold this standard—right? Historically speaking though, a hospital possessed no affirmative duty to provide treatment or any standard of care.<sup>4</sup> This is likely an alarming revelation as the idea of being turned away from a medical facility, despite suffering from a life-threatening illness, seems utterly unfathomable. Thankfully, early hospitals did not make a habit of refusing treatment to those in need and provided necessary, charitable care.<sup>5</sup> It was not until the mid-twentieth century, when the costs of healthcare dramatically increased and medical facilities began to take shape as a business, that it became clear that physicians and hospitals possessed no affirmative duty to provide treatment—much to the detriment of the uninsured.<sup>6</sup>

With the innovation of technology and diagnostic procedures, hospitals began to take shape as centralized medical facilities responsible for entire populations.<sup>7</sup> Prior to this growth, hospitals were generally used as “custodial institutions for undesirables” including the sick, indigent, and mentally unbalanced.<sup>8</sup> The nineteenth and twentieth centuries, however, saw the introduction of life-saving drugs and treatments that ultimately transformed the American medical profession from needing an estimated additional 200,000 beds in 1947<sup>9</sup> to staffing 931,203 beds in

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<sup>2</sup> Robert H. Shmerling, *First, do no harm*, HARV. HEALTH PUB.: HARV. MED. SCH. (Oct. 13, 2015, 8:31 AM), <https://www.health.harvard.edu/blog/first-do-no-harm-201510138421> [<https://perma.cc/6DYF-44FF>].

<sup>3</sup> See Michael Kowalski, *Applying the “Two Schools of Thought” Doctrine to the Repressed Memory Controversy*, 19 J. LEGAL MED. 503, 505 (1998) (recognizing that “first do no harm” is a “phrase recognized as one of the most significant admonitions from the Hippocratic Oath.”).

<sup>4</sup> Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186, 1191–92 (1986).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 1193–94.

<sup>7</sup> Michael A. Wolff, *Charity Means Business: Medicare Reimbursement for Hospitals’ ‘Free Care’ Obligations*, 25 ST. LOUIS U. L.J. 389, 393 (1981).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at 392.

2019.<sup>10</sup> This growth, of course, increased the cost of healthcare<sup>11</sup> and physicians and medical facilities were incentivized to turn away patients unable to pay their medical bills.<sup>12</sup> One terrifying example of this occurred in 1980, when an uninsured man presented to an emergency room in St. Louis, Missouri with a steak knife lodged in his spine.<sup>13</sup> The hospital and its staff refused to remove the weapon until the man could produce \$1,000.00 in cash.<sup>14</sup> By forcing the uninsured—who are more often than not homeless, indigent, or immigrants—to pay up front or not be treated at all, a hospital is able to avoid the financial burden of caring for patients who will never be able to pay their soaring medical bills. This avoidance became known as “patient dumping,” a practice where hospitals turned away poor patients or “dumped” them off at bus stations, public hospitals, or homeless shelters.<sup>15</sup>

In 1986, Congress recognized the threat of patient dumping and enacted a comprehensive statutory scheme known as the Consolidated Omnibus Budget Reconciliation Act (“COBRA”).<sup>16</sup> The vast majority of COBRA is unrelated to the concerns of patient dumping, focusing on insurance and healthcare plans; within COBRA, however, is the Emergency Medical Treatment and Active Labor Act (“EMTALA”), a series of regulations imposing standards of care on physicians and hospitals that must be met when an individual presents to an emergency room and requests treatment.<sup>17</sup> Fittingly, EMTALA is referred to as the “antidumping statute,”<sup>18</sup> as it is a targeted attempt at ensuring that hospitals do not engage in patient hot potato with each other. At its inception, Congress believed that it would be a

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<sup>10</sup> *Fast Facts on U.S. Hospitals, 2020*, AM. HOSP. ASS’N, <https://www.aha.org/statistics/fast-facts-us-hospitals> [<https://perma.cc/99CT-LT85>] (last modified Jan. 2020).

<sup>11</sup> Wolff, *supra* note 4, at 393.

<sup>12</sup> Treiger, *supra* note 4, at 1193–94; see generally Maria O’Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 BYU L. REV. 971, 972–73 (1992) (discussing the needs of the uninsured in a healthcare system that works as a business rather than a caretaker).

<sup>13</sup> George J. Annas, *Your Money or Your Life: ‘Dumping’ Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74 (1986).

<sup>14</sup> *Id.*

<sup>15</sup> Will Jay Pirkey, *A Shameful Practice*, 39 L.A. LAW. 20, 21 (2016). Importantly, it should be noted that patient dumping is not a new concern, as the term was first coined in the late 1870s. *Id.* at 20. It was not until the 1980s however, that the public outrage for patient dumping grew when several highly publicized patient dumps hit the press. See 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, 650–54 (2007). When the public learned of such “cold, unconscionable disregard for human life,” concern grew, and Congress was forced to act. Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcoming of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 175 (2002).

<sup>16</sup> Gionis et al., *supra* note 15, at 181.

<sup>17</sup> *Id.* at 182–84; 42 U.S.C. § 1395dd (2012). It should be noted that the standards of EMTALA garnered decades of jurisprudence over both the constitutionality of the Act and the scope of its language. See generally E. H. Morreim, *EMTALA Turns 30: Unconstitutional from Birth*, 28 HEALTH. LAW. 32 (2015) (discussing how EMTALA violates the Fifth Amendment’s Taking Clause); Lawrence E. Singer, *Look What They’ve Done to my Law: COBRA’s Implosion*, 33 HOUS. L. REV. 113, 162–63 (1996) (discussing how the language of EMTALA implicates not just intentional actions, but also negligent actions).

<sup>18</sup> Decanda M. Faulk, *EMTALA: The Real Deal*, 16 HEALTH LAW. 10, 10 (2003).

weapon for victims of patient dumping.<sup>19</sup> In practice, however, the Act bred far more problems than solutions, in part because it places the entirety of fault on the wrong party—the hospital. Recognizing and combatting the problem of patient dumping cannot be one-sided; Congress must look at *why* hospitals send the uninsured away, which is assuredly not because of a cold-hearted desire to watch the uninsured suffer. It is far more likely that the true reasoning for sending patients away is the rising costs of healthcare, which EMTALA does nothing but exacerbate. Under EMTALA, it is the hospital that is required to provide a level of treatment to all individuals—regardless of their ability to pay.<sup>20</sup> Hospitals are forced to pay out millions of their own funds to cover the treatment costs of the uninsured<sup>21</sup> and as the statute is an unfunded mandate, these hospitals are *never* reimbursed for these payments.<sup>22</sup> As one can imagine, this is a significant financial burden on our medical facilities which is why scholars have railed against the effects of EMTALA since its enactment.<sup>23</sup>

Importantly, this Note does not seek to build on past discussions of the financial burdens associated with EMTALA compliance, but rather it explores the consequences of a medical facility’s failure to meet its standards, including what is known as “civil money penalties.”<sup>24</sup> EMTALA’s civil money penalties are levied against violating hospitals not equally, but based on the facilities’ capacity—its total number of beds.<sup>25</sup> Under this facially-discriminatory punishment, the more beds a facility houses, the greater the penalty it faces for violations.<sup>26</sup> The civil money penalties were recently adjusted for inflation in 2017, and it is this increase that sparked the arguments herein. Specifically, Part I reviews the general requirements of EMTALA and the possible penalties that physicians and medical facilities face for violations. Part II will briefly explain the 2017 inflation increase, noting how the civil money penalties have more than doubled as a result. Part III analyzes how EMTALA’s capacity-based penalties pose a significantly higher burden on inner-city hospitals given the increased population of uninsured individuals in major cities in comparison to rural areas. Part IV offers a solution to this burden by arguing that the capacity-based penalty should be abolished. It also considers the possible ramifications of said solution and concludes that regardless of the risks, EMTALA’s capacity-based penalty structure must be reevaluated in light of its burden to inner-city hospitals.

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<sup>19</sup> Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 175–76 (1989).

<sup>20</sup> See 42 U.S.C. § 1395dd.

<sup>21</sup> Morreim, *supra* note 17, at 32.

<sup>22</sup> Thomas K. Hyatt, *Access to Health Care: 50 Years of Growth, but an Uncertain Future*, 10 J. HEALTH & LIFE SCI. L. 88, 101 (2017).

<sup>23</sup> E.g., Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 166–68 (2004).

<sup>24</sup> 42 U.S.C. § 1395dd(d)(1).

<sup>25</sup> *Id.*; 45 C.F.R. § 102.3 (2018).

<sup>26</sup> See *id.*

## I. THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT

As stated above, the Emergency Medical Treatment and Labor Act (“EMTALA”), codified as 42 U.S.C. § 1395dd, was enacted in 1986 to prevent medical facilities from withholding life-saving treatment based on a patient’s ability to pay. Importantly though, EMTALA was specifically targeted and structured to burden hospitals’ *emergency rooms*, the primary providers of treatment for the uninsured both then and now.<sup>27</sup> Given that its requirements are only imposed on facilities with emergency rooms—and in addition to that, only those facilities who participate in the federal Medicare program<sup>28</sup>—one might assume that EMTALA and its requirements are not widespread in their enforcement. This is incorrect. The vast majority of medical facilities participate in the Medicare program and operate emergency rooms, which thus, subjects them to EMTALA’s provisions.<sup>29</sup> And in fact, since EMTALA’s creation, many Medicare-participating facilities have closed their emergency rooms altogether to avoid the financial burdens of EMTALA.<sup>30</sup> As this Part discusses below, those financial burdens take shape through EMTALA’s requirements and penalties.

A. *The Requirements Of EMTALA: 42 U.S.C. § 1395(a)–(c)*

The requirements of EMTALA are codified in its first three provisions, 42 U.S.C. § 1395dd(a)–(c).<sup>31</sup> At its simplest, the statute provides that when an individual comes to an emergency room of a Medicare-participating facility for examination or treatment, the facility must “provide for an appropriate medical screening examination within the capability of the hospital’s emergency department” in order to determine if an “emergency medical condition” exists.<sup>32</sup> Then, if such a condition exists, the facility must provide, within its capabilities, whatever is necessary to “stabilize the medical condition”<sup>33</sup> or, in the alternative, the facility must provide

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<sup>27</sup> Jack Vihstadt, *EMTALA’s Impact on Patients’ Rights in Colorado Emergency Rooms*, 89 U. COLO. L. REV. 219, 224 (2018). In fact, the Centers for Disease Control and Prevention posted a study of United States emergency room visits finding that in 2016, there were more than 145 million visits. *National Center for Health Statistics: Emergency Department Visits*, CTRES. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/nchs/fastats/emergency-department.htm> [https://perma.cc/5AG9-ADCJ] (last visited Nov. 1, 2019). Note that for 39% of these visits, roughly 56 million, the patient was seen in fewer than fifteen minutes, which likely means the patient was not critically injured. *Id.*

<sup>28</sup> 42 U.S.C. § 1395cc(l) (2012); Hyatt, *supra* note 22, at 101.

<sup>29</sup> Hyatt, *supra* note 22, at 101.

<sup>30</sup> Jeffrey A. Singer, *No Discharge: Medicaid and EMTALA*, 37 REG. 52, 56–57 (2014).

<sup>31</sup> 42 U.S.C. § 1395dd(a)–(c) (2011).

<sup>32</sup> § 1395dd(a). EMTALA provides a definition of “emergency medical condition,” stating that it is a condition that the “absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part[.]” § 1395dd(e)(1).

<sup>33</sup> § 1395dd(b)(1)(A). Currently there exists a circuit split on what constitutes “stabilizing” the patient. Specifically, the Fourth and Ninth Circuit Courts view this requirement met when the patient is admitted to the hospital as an inpatient. *Bryan v. Rectors*, 95 F.3d 349, 352 (4th Cir. 1996), *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1164 (9th Cir. 2002). In contrast, the Sixth Circuit reasons that the frequent use of the term “emergency room” in EMTALA was a reference to Congress’s desire to

transfer to another, better-equipped facility.<sup>34</sup> Notably, however, a transfer is conditioned on the patient’s written consent and a physician’s signed certification that the benefits at another facility outweigh the risks of a transfer.<sup>35</sup> Interestingly, the receiving hospital must accept the patient being transferred if it is within its capacity and specialized capability<sup>36</sup>—regardless of whether or not it has an emergency room to subject it to the provisions of EMTALA.<sup>37</sup> Thus, even though EMTALA’s requirements bind only those facilities who participate in the Medicare program and operate an emergency room, EMTALA can still affect all medical facilities.

What should be evident upon reading the aforementioned provisions is that a hospital’s compliance with EMTALA is a substantial financial burden. For example, the requirement that a hospital perform a medical screening alone can represent a spectrum of procedures from “a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures.”<sup>38</sup> Similarly, what constitutes “stabilization” of an existing emergency medical condition can be “brief or long depending on the condition [of the patient].”<sup>39</sup> Recall that EMTALA is an unfunded mandate, and regardless of what is needed to “screen” and “stabilize” the patient, the hospital is required to furnish the entire bill.<sup>40</sup> Perhaps one of the most controversial political topics of American twenty-first century debate is whether healthcare needs to be government-mandated or continue to be privatized;<sup>41</sup> however, if you put the debate in the context of

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ensure patients received emergency care regardless of admittance or not. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990).

<sup>34</sup> 42 U.S.C. § 1395dd(b)(1)(B).

<sup>35</sup> § 1395dd(b)(3). While it may not be evident by reading the statutes alone – the costs of meeting EMTALA’s standards are significant. There does, however, exist a small saving grace for hospitals – especially rural hospitals with limited resources. Specifically, EMTALA provides that the required treatment must only be “within the capability of the hospital’s emergency department,” thus protecting rural hospitals that might be unable to match the capabilities of an urban facility. § 1395dd(g). Scholars have pointed to this language as helpful to rural hospitals that cannot match the capabilities of an urban facility. *See, e.g.*, Diane S. Mackey, *The Emergency Medical Treatment and Active Labor Act: An Act Undergoing Judicial Development*, 19 U. ARK. LITTLE ROCK L.J. 465, 478 (1997). Of course, however, if a hospital cannot provide the necessary treatment, it must foot the financial burden of transferring the patient to a facility that can. *See id* at 470.

<sup>36</sup> E. H. Morreim, *EMTALA: Medicare’s Unconstitutional Conditions on Hospitals*, 43 HASTINGS CONST. L.Q. 61, 62 n.5 (2015).

<sup>37</sup> 42 C.F.R. § 489.24(f) (2013).

<sup>38</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICARE MEDICAID STATE OPERATIONS MANUAL, APPENDIX V, at 36 (1998). By this language, the screening requirement of EMTALA is satisfied simply because the individual met with a physician; depending on the circumstances, further tests and evaluations may be required to determine with reasonable certainty if there is an emergency medical condition. Wendi Campbell Rogaliner et al., *Health Care Providers Balance Patient Rights and Law Enforcement Authority in the Hospital Setting*, 11 J. HEALTH & LIFE SCI. L. 42, 52 (2018).

<sup>39</sup> Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J. L. MED. & ETHICS 590, 592 (2003).

<sup>40</sup> *See* Hyatt, *supra* note 22, at 101.

<sup>41</sup> *E.g.*, James Pramuk, ‘Medicare-for-all’ vs. the public option: How health care could shape the Democratic primary race to take on Trump in the 2020 election, CNBC (Mar. 10, 2019, 8:00 AM), <https://www.cnbc.com/2019/03/06/2020-democratic-primary-candidates-weigh-medicare-for-all-public-option.html> [<https://perma.cc/3CML-KBB5>].

EMTALA, the public would realize that we already enjoy a version of universal, government-mandated healthcare—one that places the entire financial burden not on the taxpayers, but on the medical facility itself.<sup>42</sup>

As noted above, the focus of this Note is not to add to the existing scholarship discussing the financial burdens of EMTALA's requirements, but to focus instead on the penalties of EMTALA. Nevertheless, it is important to understand the basic requirements and the financial costs imposed on medical facilities in complying with EMTALA in order to see the offset of financial costs imposed for a hospitals' non-compliance. The Center for Medicare and Medicaid Services ("CMS"), a division of the United States Department of Health and Human Services, is responsible for enforcing and regulating medical facilities' compliance with the aforementioned provisions of EMTALA.<sup>43</sup> In the event that a medical facility violates the provisions of EMTALA, the statute provides the CMS—and even the actual victims of patient dumping—a number of possible punishments and remedies to invoke that are explained in this Part below.

#### *B. The Penalties Of EMTALA: 42 U.S.C. § 1395dd(d)*

While the prior section summarized the requirements of EMTALA's first three provisions, this section illustrates the five penalties for a hospitals' failure to meet said requirements, all of which are codified in EMTALA's fourth provision, 42 U.S.C. § 1395dd(d).<sup>44</sup> As will be shown, each EMTALA penalty imposes its own unique financial burden on a medical facility and its physicians, evidencing Congress's strong intentions with respect to curtailing all instances of patient dumping. It should be noted that none of the following available penalties are exclusive, and a hospital may be held responsible under *each* penalty for *each* violation depending on the given circumstances.<sup>45</sup>

The first possible penalty of EMTALA, which is arguably the most severe, is the termination of a hospitals' Medicare provider agreement as provided for in 42 U.S.C. § 1395dd(d)(1)(B). Scholars recognize this as the "real economic weapon" of EMTALA,<sup>46</sup> as the termination of a hospitals' Medicare agreement can cost the

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<sup>41</sup> 42 U.S.C.A. § 1395dd(d) (2012).

<sup>42</sup> By enacting EMTALA, the statute became the "de facto" healthcare insurance for the uninsured. See *EMTALA Fact Sheet*, AM. COLL. EMERGENCY PHYSICIANS, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/> [<https://perma.cc/9YG6-2DPN>] (last visited Mar. 15, 2019).

<sup>43</sup> See Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 701 (2006).

<sup>44</sup> 42 U.S.C. § 1395dd(d) (2011).

<sup>45</sup> See generally Shannon Fruth, *Medical Repatriation: The Intersection of Mandated Emergency Care, Immigration Consequences, and International Obligations*, 36 J. LEGAL MED. 45, 51 (2015). See also 42 U.S.C.A. § 1395dd (there is no provision dictating that the penalties under EMTALA are exclusive). A hospital can be fined by the OIG, sued by a neighboring hospital, sued by a private plaintiff, and lose its Medicare funding all at once depending on the circumstances.

<sup>46</sup> Michael J. Frank, *Tailoring EMTALA Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 218 (2000) (citations omitted).

facility millions of dollars in funding and loss of reputation.<sup>47</sup> In fact, for a majority of hospitals, Medicare funding represents more than thirty percent of the budget and roughly fifty-five percent of the revenue.<sup>48</sup> Its loss can constitute a death sentence for many facilities.<sup>49</sup> Under EMTALA, however, this penalty is reserved for “gross and flagrant” violations or repeated violations, and therefore is not routinely invoked.<sup>50</sup> Notwithstanding its rarity, it remains the loaded gun of EMTALA that bullies facilities into compliance or shutting their emergency departments down altogether.

A second possible penalty codified by EMTALA is one against the individual physician, as provided for in 42 U.S.C. § 1395dd(d)(1)(B). In the event that a physician negligently violates a requirement of EMTALA, that individual physician is subject to a civil money penalty of up to \$50,000.00 for each of his or her violations.<sup>51</sup> Much like the previous penalty of EMTALA, this penalty is a rarity. In 2017, a study was published analyzing 196 civil money penalty settlements made over a thirteen-year period.<sup>52</sup> Of these settlements, only eight (roughly four percent) were made against the individual physician and the penalty ranged from \$10,000.00 to the full \$50,000.00.<sup>53</sup> Only one physician was penalized with the full \$50,000.00 fine, which was levied for failure to respond to a request to evaluate a patient who later died.<sup>54</sup> Thus, while this penalty is clearly not enforced often, the statistics of the 2017 study nonetheless prove that EMTALA’s head enforcer, the Office of the Inspector General (“OIG”), is not opposed to penalizing individual physicians. Consequently, the threat of a lofty individual penalty remains an “often-feared consequence” of EMTALA for physicians.<sup>55</sup>

The third possible penalty of EMTALA is the private statutory cause of action provided for in 42 U.S.C. § 1395dd(d)(2)(A),<sup>56</sup> which allows victims of patient dumping to bring a direct action against the violating hospital for monetary remedies. Importantly, however, this remedy has its limitations. For one, the action may only be brought against the hospital—not the physician.<sup>57</sup> Also, the existence of a private,

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<sup>47</sup> Christopher J. Young, *Emergency! Says Who?: Analysis of the Legal Issues Concerning Managed Care and Emergency Medical Services*, 13 J. CONTEMP. HEALTH L. & POL’Y 553, 562–63 (1997).

<sup>48</sup> Morreim, *supra* note 17, at 38.

<sup>49</sup> Unsurprisingly, those hospitals where Medicare represents roughly fifty-five percent of its revenue are more likely to be urban facilities. Mark R. Whitmore & J. Scott Anderson, *Decisions of the Supreme Court and DHHS Continue to Expand Hospital Liability Under EMTALA*, 11 HEALTH LAW. 14, 14 (1999).

<sup>50</sup> 42 U.S.C. § 1395dd(d)(1)(B) (2011).

<sup>51</sup> *Id.*

<sup>52</sup> Sophie Terp et al., *Individual Physician Penalties Resulting From Violation of Emergency Medical Treatment and Labor Act: A Review of Office of the Inspector General Patient Dumping Settlements, 2002–2015*, 24 ACAD. EMERGENCY MED. 442, 442 (2017).

<sup>53</sup> *Id.* at 444 (providing a breakdown of the eight penalized physicians by chart).

<sup>54</sup> *Id.*

<sup>55</sup> *Id.* While this particular penalty is levied against individual physicians, it still poses a financial burden to the hospital the physician works for. For instance, what if a physician violates EMTALA, but he or she is under contract with their hospital? EMTALA could force a hospital into litigation with its doctors and raise recruitment costs to replace violating doctors. Thus, this individual penalty has likely “as applied” costs to the hospitals.

<sup>56</sup> 42 U.S.C. § 1395dd(d)(2)(A) (2018); *See also* Julie A. Braun et al., *Recent Developments in Medicine and Law*, 36 TORT & INS. L.J. 463, 469–70 (2001).

<sup>57</sup> Young, *supra* note 45, at 563.

federal cause of action does not necessarily preempt the existing, substantive law of a given state.<sup>58</sup> For example, EMTALA does not compete with state medical malpractice law as EMTALA itself is not a federal malpractice statute.<sup>59</sup> Congress did not intend for EMTALA to address injuries already covered by state law.<sup>60</sup> Nevertheless, plaintiffs still tack on EMTALA claims in conjunction with state malpractice actions simply because the alleged incident occurred in an emergency room.<sup>61</sup> The crucial distinction between these claims is that a hospital is ordinarily not liable for its physicians' malpractice, but it *is* liable for its physicians' EMTALA violations.<sup>62</sup> Thus, by adding an EMTALA cause of action pursuant to 42 U.S.C. § 1395dd(d)(2)(A), a plaintiff may force a hospital into malpractice litigation that it would not otherwise be a party to, costing the hospital thousands in attorney's fees and costs. This third penalty of EMTALA has drastically altered the nature of medical law, allowing EMTALA to reach beyond a simple patient dumping case.<sup>63</sup>

A fourth EMTALA penalty, codified in 42 U.S.C. § 1395dd(d)(2)(B), is a second statutory, civil cause of action available to medical facilities. In the event that a hospital suffers damages due to *another* hospital's violation of EMTALA, the injured hospital may bring suit to recover its damages.<sup>64</sup> After much research, however, it is important to note that there exists little evidence that this penalty is ever utilized by injured hospitals. The reason for this rarity is likely because hospitals—and the medical profession as a whole—are historically united in their disdain for EMTALA and its unreasonable burdens.<sup>65</sup> It is also possible that hospitals rarely invoke this penalty because their damages are simply too difficult to quantify or to discover in the two-year statute of limitations imposed by EMTALA.<sup>66</sup> Since the statute of limitations begins to run from the date of the violation, it is entirely possible that hospitals simply do not discover the violation in time to sue. Another possible reasoning for hospitals' decisions to not invoke this penalty may simply be that they have a desire to keep amicable and fruitful relationships with their neighboring facilities.<sup>67</sup> Nevertheless, regardless of the reasoning, this fourth penalty of EMTALA remains toothless by practice.

The final possible penalty of EMTALA—and the fuse for this Note—is the civil money penalty imposed on violating facilities pursuant to 42 U.S.C. § 1395dd(d)(1)(A). Prior to 2017, if a hospital violated EMTALA, it faced a civil

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<sup>58</sup> See 42 U.S.C.A. § 1395dd(f) (2018); See also Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 129 (2016).

<sup>59</sup> See Julia Ai, *Does EMTALA Apply to Inpatients Located Anywhere in a Hospital?*, 32 RUTGERS L.J. 549, 571 (2001) (citing *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996)).

<sup>60</sup> Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463, 512 (1996).

<sup>61</sup> Ai, *supra* note 57, at 572.

<sup>62</sup> Dowdy et al., *supra* note 58, at 468–69.

<sup>63</sup> Ai, *supra* note 57, at 572.

<sup>64</sup> 42 U.S.C. § 1395dd(d)(2)(B) (2018).

<sup>65</sup> See Frank, *supra* 44, at 235.

<sup>66</sup> 42 U.S.C. § 1395dd(d)(2)(C) (2018); See also Kim C. Stanger, *Private Lawsuits Under EMTALA*, 12 HEALTH LAW. 27, 33 (2000).

<sup>67</sup> After working two years at a state medical facility, I witnessed firsthand how hospitals work to keep their relationships smooth and cooperative for the sake of their patients.



money penalty of either \$25,000.00 or \$50,000.00 depending on its bed capacity.<sup>68</sup> Those medical facilities with less than 100 beds received the lesser penalty of \$25,000.00; and those facilities with more than 100 beds would face the full \$50,000.00 penalty.<sup>69</sup> Given this facial discrepancy, imagine the following scenario: an inner-city hospital with 115 beds treats patients that are roughly ninety percent uninsured, while a rural hospital with eighty beds treats patients that are roughly ten percent uninsured. Despite the difference in patient insurance coverage, the inner-city hospital is punished twice as severely simply because it has more than 100 beds. Notably, the difference in penalty has nothing to do with the circumstances of the actual violation—meaning that the rural hospital will still receive the lesser punishment even though its violation resulted in the death of a patient, while the urban facility will still receive the higher penalty even though its patient survived.<sup>70</sup>

In the event that a hospital violates the requirements of EMTALA, the OIG levies these civil money penalties through discretionary, administrative actions.<sup>71</sup> Notably, of the preceding five possible EMTALA penalties, this fifth penalty is arguably the most invoked. In fact, a 2001 study demonstrated that from 1995 to 2000, the OIG collected more than five million in fines from violating hospitals and physicians.<sup>72</sup> More recently, a 2017 study found that from 2002-2015 more than a quarter of hospitals were cited for violations.<sup>73</sup> Noticeably lacking from both studies, however, is any consideration or analysis of the capacity-based structure of this fifth penalty.<sup>74</sup> It is currently unknown how many of these cited hospitals housed more or less than 100 beds as both studies focus on the actual assessment of this penalty and not the penalty assessed itself. As will be discussed later in Part III, this is an oversight in EMTALA scholarship as the capacity-based structure of this fifth penalty is discriminatory to inner-city hospitals, which has only been exacerbated by the 2017 inflation adjustment described in this next Part.

## II. THE 2017 CIVIL MONEY PENALTY INCREASE DUE TO INFLATION

In accordance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, the Department of Health and Human Services (“DHHS”), which oversees the Center for Medicare and Medicaid Services

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<sup>68</sup> 42 U.S.C.A. § 1395dd(d)(1).

<sup>69</sup> *Id.*

<sup>70</sup> Importantly, EMTALA’s civil money penalties are per violation, and not per patient. Robert A. Bitterman, *Feds Increase EMTALA Penalties against Physicians and Hospitals*, EMERGENCY PHYSICIANS MONTHLY (Oct. 17, 2017), <http://epmonthly.com/article/feds-increase-emtala-penalties-physicians-hospitals/> [https://perma.cc/C76V-JQSU]. This is significant because multiple EMTALA violations can occur with a single patient. *Id.*

<sup>71</sup> Brian Kamoie, *EMTALA: Dedicating an Emergency Department Near You*, 37 J. HEALTH L. 41, 45 (2004); See also Charlotte Fillenwarth, Note, *Beyond the Emergency Room Doors: Rejecting Patient Admittance as Satisfaction of Hospital Obligations Under EMTALA*, 11 IND. HEALTH L. REV. 791, 805 (2014) (“... the CMS may terminate the hospital’s Medicare agreement and the OIG determines whether to impose civil penalties.”) (emphasis added).

<sup>72</sup> Kamoie, *supra* note 71, at 45.

<sup>73</sup> Terp, *supra* note 52, at 444.

<sup>74</sup> See *id.*; See also U.S. GOV’T ACCOUNTABILITY OFF., GAO-01-747, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES (2001).

(“CMS”), began updating its regulations for inflation—including EMTALA and its civil money penalties.<sup>75</sup> Its claimed reasoning was to “improve the effectiveness of civil monetary penalties” and to ultimately maintain their deterrent effect.<sup>76</sup> As a result, the civil monetary penalty for an EMTALA-violating hospital is now \$52,414.00 for facilities with less than a hundred beds and \$104,826.00 for those facilities with more than a hundred beds.<sup>77</sup> Notably, these new figures are more than *twice* the amount of the previous EMTALA penalties; though, given that EMTALA was first enacted over thirty years ago, it is not unheard of that an inflation adjustment would double the original penalty. Nevertheless, it is a fair assumption that this drastic increase to EMTALA’s penalties will not minimize the financial burdens of the statute discussed in Part I, but rather exacerbate its many faults—including the unfortunate closing of many facilities.

A 2017 study found that in the past decade, “more than twice as many hospitals were closed or downgraded emergency services as a result of EMTALA violations” as compared to those individually fined physicians.<sup>78</sup> Scholars posit that the overall burdens of EMTALA’s requirements and penalties are responsible for these closures and downgrades.<sup>79</sup> What is rarely considered, however, is *which* hospitals are being burdened the most and why. Is the eighty-bed rural facility from our example in Part I more impacted by EMTALA’s financial costs, or is the 115-bed urban facility the true sufferer at risk of closure? Only a handful of researchers recognize that EMTALA, as a whole, disproportionately burdens inner-city facilities because such facilities carry the brunt of caring for this country’s uninsured population.<sup>80</sup> This Note joins this discussion, but also goes a step further and argues that the capacity-based fifth penalty of EMTALA, as shown in Part I to unfairly penalize larger

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<sup>75</sup> *Annual Civil Monetary Penalties Inflation Adjustment*, FED. REG. (Jan. 30, 2017), <https://www.federalregister.gov/documents/2017/02/03/2017-02300/annual-civil-monetary-penalties-inflation-adjustment> [<https://perma.cc/7K7Q-8HFS>]. Importantly, it should be noted that the 2017 inflation adjustment to EMTALA’s civil money penalties is technically no longer current. The adjustment was made pursuant to the Federal Civil Penalties Inflation Adjustment Act, signed into law by Barack Obama on November 2, 2015. *Civil Monetary Penalties (Annual Adjustments)*, CMS.GOV (Feb. 12, 2019 7:20 AM), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Civil-Monetary-Penalties-Annual-Adjustments> [<https://perma.cc/R6EF-B3EG>]. Under this Act, agencies are required to continuously update their penalties for inflation *annually*. *Id.* Thus, in 2018 EMTALA’s civil money penalty was adjusted again to be a \$106,965.00 penalty if the facility houses more than 100 beds and \$53,484 if it houses less than 100 beds. *Id.* These numbers are nominally different from the 2017 inflation adjustment, which more than doubled EMTALA’s original penalties in a single year. The doubling effect of the 2017 adjustment is why only the 2017 numbers are discussed.

<sup>76</sup> *Id.*

<sup>77</sup> 45 C.F.R. § 102.3 (2018). These numbers took effect February 3, 2017 unless the alleged violation occurred prior to November 2, 2015 or the penalty was assessed prior to September 6, 2016, in which case the prior figures were still in effect. *Annual Civil Monetary Penalties Inflation Adjustment*, *supra* note 75.

<sup>78</sup> Terp, *supra* note 52, at 445.

<sup>79</sup> *E.g.*, Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden it Places on Hospitals*, 7 J. L. SOCIETY 146, 154–55 (2005). Moreover, with any hospital closure, neighboring hospitals become burdened with more patients and overcrowded emergency rooms, which causes the neighboring hospitals to be in danger of closure. *See* Vivian L. Regehr, *Please Resuscitate! How Financial Solutions May Breathe Life into EMTALA*, 30 U. LA VERNE L. REV. 180, 187–88 (2008).

<sup>80</sup> *E.g.*, Lebedinski, *supra* note 79, at 155.

facilities more so than smaller ones, discriminatorily impacts inner-city facilities and should consequently be abolished.

### III. THE BURDEN ON HIGHLY POPULATED, INNER-CITY REGIONS

As noted in Parts I and II, the civil money penalties of EMTALA are levied against medical facilities based on their overall bed capacity—those facilities with less than a hundred beds are fined up to \$52,414.00 for each violation, and those with more than a hundred beds are fined up to \$104,926.00 for each violation. Yet, despite the plethora of scholarship currently existing on EMTALA’s requirements and burdens, scholars have never examined the effect that this capacity-based penalty has on medical facilities, particularly those located in highly populated, inner-city regions. In light of the penalty’s recent inflation adjustment, this Note (and more specifically this Part) breaches that gap in scholarship and posits that the capacity-based penalty is facially discriminatory to inner-city facilities that are, by virtue of their location and size, entirely responsible for the medical care of this country’s uninsured population.

For clarity, the logic of this Part can be condensed as follows: First, a sizeable population of uninsured Americans—a great majority of which are homeless—currently live in the United States. Second, statistics show that this uninsured, homeless population likely live in highly populated, inner-city regions. Third, hospitals with more than a hundred beds likely are located in highly populated, inner-city regions in order to accommodate their vast populations. Accordingly, inner-city hospitals treat the majority of the country’s uninsured and homeless; yet, by virtue of their size alone, these hospitals face double the penalty for violating EMTALA than that of a smaller facility that treats little to no uninsured patients. As EMTALA was enacted to prevent medical facilities from turning away the uninsured population, the capacity-based penalty of EMTALA is therefore unfairly discriminating against inner-city facilities who treat said population.

With respect to the first point, as of 2016, the United States Census determined that roughly twenty-seven million people living in the United States lacked health insurance coverage.<sup>81</sup> This figure alone is enough to support the arguments herein; however, it should be noted that it represents only those the United States Census surveyed.<sup>82</sup> Historically speaking, the Census is notorious for its inability to accurately determine the number of homeless and indigent people living in the United States,<sup>83</sup> and therefore it is likely that this figure is much larger in actuality.<sup>84</sup>

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<sup>81</sup>Edward Berchick, *Who are the Uninsured?*, U.S. CENSUS BUREAU (Sept. 14, 2017), [https://www.census.gov/newsroom/blogs/random-samplings/2017/09/who\\_are\\_the\\_uninsured.html](https://www.census.gov/newsroom/blogs/random-samplings/2017/09/who_are_the_uninsured.html) [<https://perma.cc/4V3G-QE9U>]. This number increased to twenty-eight million in 2017. Edward Berchick, *Who Are the Uninsured?*, U.S. CENSUS BUREAU (Sept. 12, 2018), <https://www.census.gov/library/stories/2018/09/who-are-the-uninsured.html> [<https://perma.cc/BL48-CBB2>].

<sup>82</sup>See Berchick (Sept. 14, 2017), *supra* note 81.

<sup>83</sup>Ann M. Burkhart, *The Constitutional Underpinnings of Homelessness*, 40 HOUS. L. REV. 211, 275 (2003).

<sup>84</sup>See *id.* at 274–75 (“Registration requirements disproportionately affect the homeless in at least three ways. First, the cost and effort to register generally are greater for the poor than for those who are

Moreover, since the new administration took office, statistics show that the uninsured population has spiked upward for the first time since the Affordable Care Act (“ACA”) was enacted in 2010.<sup>85</sup> In the coming years, the number will likely continue to increase in light of this administration’s hostility toward the ACA.<sup>86</sup> Nevertheless, it is important to recognize how the population of the uninsured affects medical facilities and their compliance with EMTALA. For one, the uninsured are more likely to be younger and minorities—the “two subpopulations that are disproportionately represented among the homeless.”<sup>87</sup> It is the homeless population that frequents emergency departments as their “primary or only source of health care.”<sup>88</sup> Consequently, hospitals who treat the uninsured homeless are more at risk for EMTALA violations because these individuals cannot pay for their care.

But which hospitals treat the highest rates of uninsured, and by extension, are more at risk for violating EMTALA? The answer depends on where the uninsured, homeless population live. With respect to the second point of this argument, a 2018 study broke down the rates of homelessness by city, finding that “[h]alf... of all people experiencing homelessness are in one of five states – California (129,972 people), New York (91,897), Florida (31,030), Texas (25,310) and Washington (22,304).”<sup>89</sup> Tellingly, California, Texas, Florida, and New York rank as the top four most populous states in the country.<sup>90</sup> The 2018 study further found that the ten cities with the highest rates of homelessness included: New York City, New York; Los Angeles, California; Seattle, Washington; San Diego, California; San Jose, California; District of Columbia, DC; San Francisco, California; Phoenix, Arizona; Boston, Massachusetts; and Las Vegas, Nevada.<sup>91</sup> All of these cities fall within the

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more affluent, whether due to the necessity for a bus ride or other inconvenience of the registration time or place. Second, only nine states’ election laws expressly enfranchise the homeless. In those jurisdictions that do not, registration officials often refuse a homeless person the right to register. In some cases, election registrars prevent homeless persons from voting even if they have registered. Finally, many states check on the continued residence of registered voters by mailed notice, and any addressee who does not respond to the notice is purged from the registration list. This practice obviously presents greater difficulties for the homeless than for those with a home. The cumulative impact of these obstacles is as impossible to determine as determining the exact number of homeless persons.” (internal footnotes omitted)).

<sup>85</sup> E.g., Rachana Pradhan, *Number of uninsured Americans rises for the first time since Obamacare*, POLITICO (Sept. 10, 2019, 10:59 AM), <https://www.politico.com/story/2019/09/10/health-insurance-rate-1719381> [https://perma.cc/4ARR-Y3VG].

<sup>86</sup> See *id.*

<sup>87</sup> COMMITTEE ON HEALTH CARE FOR HOMELESS PEOPLE, HOMELESSNESS, HEALTH, AND HUMAN NEEDS 79–80 (1988).

<sup>88</sup> Ruirui Sun et al., *Characteristics of Homeless Individuals Using Emergency Department Services in 2014*, HEALTHCARE COST & UTILIZATION PROJECT (Oct. 17, 2017), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb229-Homeless-ED-Visits-2014.pdf> [https://perma.cc/ZL97-RL5L].

<sup>89</sup> Niall McCarthy, *The U.S. Cities with the Most Homeless People in 2018*, FORBES (Dec. 20, 2018, 7:00 AM), <https://www.forbes.com/sites/niallmccarthy/2018/12/20/the-u-s-cities-with-the-most-homeless-people-in-2018-infographic/#517363b31178> [https://perma.cc/28NW-KX97].

<sup>90</sup> *Florida Passes New York to Become the Nation’s Third Most Populous State*, Census Bureau Reports, U.S. CENSUS BUREAU (Dec. 23, 2014), <https://www.census.gov/newsroom/press-releases/2014/cb14-232.html> [https://perma.cc/BMD9-322S].

<sup>91</sup> McCarthy, *supra* note 89.

thirty most-populated cities in the United States.<sup>92</sup> Thus, the most highly populated, inner-city regions in this country are home to the largest homeless, uninsured populations. It naturally follows that their medical facilities would treat said population and be at the greatest risk for EMTALA violations.

As highly populated, inner-city regions are home to the largest uninsured, homeless populations, it is no coincidence that these same areas are also home to the largest medical facilities, which brings this Part to its third point. Hospitals with more than a hundred beds are more often located in more populous cities in order to accommodate their population.<sup>93</sup> In fact, of the twenty-five largest hospitals in the United States (measured by bed capacity), eleven are located in Florida, New York, and Texas.<sup>94</sup> Keep in mind that all twenty-five of these hospitals have more than 1,000 beds each.<sup>95</sup> Expanding further on this, of the fifty largest hospitals (measured by bed capacity), twenty-two are located in the same states, the smallest having 861 beds.<sup>96</sup> New York City alone houses seven of the largest fifty hospitals<sup>97</sup> and of its total sixty-two acute care facilities, only three have less than a hundred beds.<sup>98</sup> Consequently, these numbers reflect the fact that medical facilities located in highly populated, inner-city areas house the most beds in addition to the largest homeless, uninsured populations. Yet, despite the fact that these facilities are disproportionately forced to treat the uninsured, EMTALA nevertheless penalizes said facilities for violating its requirements solely based on their capacity, and not the given circumstances. The statute itself provides no reasoning for this capacity-based distinction and, as will be discussed in the following Part, it should be abolished altogether.

#### IV. ABOLISHING THE CAPACITY-BASED PENALTY

The existing scholarship with respect to EMTALA is a plethora of legal and medical arguments regarding its constitutionality and practicality. Perhaps justifiably, scholars and researchers predominately focus on the overall impacts and effects of EMTALA, leaving its minor nuances and provisions alone.<sup>99</sup> The reason for this is likely because a great many scholars do not propose amendments to the

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<sup>92</sup> Marian White, *The Top 10 Largest U.S. Cities by Population*, MOVING TIPS (Mar. 16, 2018), <https://www.moving.com/tips/the-top-10-largest-us-cities-by-population/> [<https://perma.cc/P8AP-U9D3>].

<sup>93</sup> See *50 Largest Hospitals in America*, BECKER'S HOSPITAL REV. (Oct. 26, 2010), <https://www.beckershospitalreview.com/lists/50-largest-hospitals-in-america.html> [<https://perma.cc/RR73-WSRH>]; see also Kelly Gooch, *25 Largest Hospitals in America*, BECKER'S HOSPITAL REV. (Jan. 18, 2017), <https://www.beckershospitalreview.com/lists/25-largest-hospitals-in-america-jan-18.html> [<https://perma.cc/6D2V-7ZVH>].

<sup>94</sup> Gooch, *supra* note 92. Note that these three states are among the five states with the largest homeless populations.

<sup>95</sup> *Id.*

<sup>96</sup> See *50 Largest Hospitals in America*, *supra* note 93.

<sup>97</sup> *Id.*

<sup>98</sup> *62 acute care hospitals in New York City*, BECKER'S HOSPITAL REV. (July 15, 2015), <https://www.beckershospitalreview.com/lists/62-acute-care-hospitals-in-new-york-city.html> [<https://perma.cc/EQZ7-8AX5>].

<sup>99</sup> See, e.g., E.H. Morreim, *Dumping the "Anti-Dumping" Law: Why EMTALA is (Largely) Unconstitutional and Why it Matters*, 15 MINN. J.L. SCI. & TECH. 211 (2014).

statute, but rather that EMTALA should be abolished as unconstitutional. Others focus on methods of funding EMTALA so that it is no longer an unfunded mandate.<sup>100</sup> This Note, though not necessarily in disagreement with prior scholarship's approach to EMTALA, proposes differently and argues that EMTALA should be amended to abolish its capacity-based civil money penalty as it discriminates against highly populated, inner-city facilities that are forced to bear the brunt of this country's uninsured population.

EMTALA was designed to be a deterrent to hospitals that might be prone to patient dumping.<sup>101</sup> Its requirements and burdens reflect Congress's sincere intention to stamp out the practice altogether and to ensure that medical facilities will think twice before sending a patient away. Given this, it makes no logical sense that Congress would draw a distinction based on bed capacity when levying EMTALA's civil money penalties against a violating hospital. Recall the example from Part I where a rural hospital with eighty beds could intentionally violate EMTALA resulting in the death of a patient and *still* only be subject to a maximum civil money penalty of \$52,414.00. In contrast, an urban facility with 115 beds could negligently violate EMTALA without causing the death of their patient and be subject to a maximum penalty of \$104,926.00. Notwithstanding the vast difference in circumstances, the urban facility will be liable for twice the penalty as the rural facility solely because of its bed capacity. This conclusion lacks reasoning and ultimately reflects the irrelevance of the capacity-based penalty.

Upon review of the legislative material for EMTALA, there appears to be no stated reasoning for the capacity-based penalty. Presumably though, it was enacted to ensure that larger hospitals that, as illustrated herein, treat the majority of the uninsured population would be more deterred from participating in patient dumping. It is also possible that Congress feared that the larger penalty would cripple smaller facilities; though the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, which requires that agencies adjust their penalties for inflation annually,<sup>102</sup> defeats such protection. Nevertheless, the reasoning seems inconsequential when scholars are in almost universal agreement that the sole deterrent of patient dumping comes from a single provision of EMTALA—the termination of a hospitals' Medicare provider agreement as provided for in 42 U.S.C. § 1395dd(d)(1)(B).<sup>103</sup> Thus, the discrimination of EMTALA's civil money penalties is unnecessary and need only be eliminated by an act of Congress. With a plethora of penalties available, levying a uniform civil money penalty against violating hospitals will have little to no consequences.

While abolishing the capacity-based structure of EMTALA's civil money penalties will likely have no negative consequences, it may also be argued that it will not have any positive consequences and is therefore unnecessary. For example, under

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<sup>100</sup> See Tristan Dollinger, *America's Unraveling Safety Net: EMTALA's Effect on Emergency Departments, Problems and Solutions*, 98 MARQ. L. REV. 1759, 1761, 1771–72 (2015).

<sup>101</sup> See *infra* Part I.

<sup>102</sup> *Civil Monetary Penalties (Annual Adjustments)*, *supra* note 75.

<sup>103</sup> See, e.g., Victoria K. Perez, *EMTALA: Protecting Patients First by not Deferring to the Final Regulations*, 4 SETON HALL CIRCUIT REV. 149, 160 (2007); George P. Smith, II, *The Elderly and Patient Dumping*, 73 FLA. B.J. 85–86 (1999); Frank *supra* note 46, at 218.

EMTALA, the OIG does not *have* to impose the maximum civil money penalty and can arguably choose to levy a smaller penalty against a hospital with more than a hundred beds. A 2016 study found that of 192 EMTALA settlement agreements from 2002-2015, the fines levied against medical facilities averaged to about \$33,435.00.<sup>104</sup> Note that during this time period, the maximum penalty for a hospital with more than a hundred beds was \$50,000.00; and one might argue that this figure evidences that the OIG was not levying the maximum penalty available. Importantly, however, this study does not clarify whether these settlement agreements were reached with hospitals with more or less than a hundred beds, or some combination thereof. It is entirely possible that the full \$50,000.00 fine was levied on some, if not all, medical facilities with more than a hundred beds. Future research will have to be conducted, taking into account the capacity-based structure of the penalty, in order to better understand its implementation and effect. Until this can be done, the positive consequences, or lack thereof, of abolishing EMTALA’s capacity-based penalty will remain unknown.

#### CONCLUSION

The overall financial burdens of EMTALA are severe regardless of whether a facility complies with the statute or not. Facilities are faced with a choice to either meet the standards of EMTALA and dole out millions in uncompensated care, fail to meet the standards of EMTALA and suffer millions in penalties, or simply submit to the closure of their facility and/or emergency services to avoid financial costs altogether. It can be argued that these burdens are the price of participating in the federal Medicare program. Hence—you take the government’s money; you play by its rules. This argument is fair considering that hospitals do have a choice to not participate in the Medicare program. In practice, however, the choice to participate in the Medicare program is not much of a choice at all. As illustrated in Part I, Medicare often represents a significant portion of a facility’s funding.<sup>105</sup> For many urban facilities, it accounts for fifty percent of its revenue.<sup>106</sup> Thus, simply severing its Medicare agreement can have devastating consequences. This is likely the reason why so many facilities have either closed altogether or downgraded their services and eliminated emergency care.<sup>107</sup> Neither result bodes well for the uninsured population of the United States.

Unlike existing EMTALA scholarship, this Note does not put forth an argument that the statute must either be repealed or funded by Congress—though these arguments certainly have merit. Rather, this Note argues that EMTALA’s capacity-based structure for its civil money penalties is unnecessary and unfairly discriminatory against inner-city facilities who are forced to carry the brunt of this

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<sup>104</sup> Nadia Zuabi et al., *Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements*, 17 WEST J. EMERG. MED. 245, 247 (2016).

<sup>105</sup> See *infra* Part I.

<sup>106</sup> Whitmore & Anderson, *supra* note 49, at 14.

<sup>107</sup> Hermer, *supra* note 43; see also David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX: J. OF LAW-MEDICINE 29, 50–52 (1998); Singer, *supra* note 30, at 57.

country's uninsured population. After all, the difference of a single bed should not be the deciding factor for whether a medical facility is subject to a fine of \$52,414.00 or a fine of \$104,926.00. The true determination should depend on the circumstances of a given case and relevant factors including whether the patient died, whether the facility's actions were intentional or negligent, or whether the facility has since implemented preventative measures to avoid the incident's reoccurrence. Moreover, removing the capacity-based structure of EMTALA's civil money penalty should not negatively impact Congress's intention to curtail patient dumping, the severity of which this Note does not seek minimize or ignore. Nonetheless, it cannot be said that EMTALA has not unfairly burdened the medical profession by forcing it to fund a version of universal healthcare. While a more in-depth reexamination of EMTALA is needed to protect hospitals and medical facilities from its burdens, abolishing the capacity-based structure of EMTALA's penalty will provide some relief to these facilities—specifically those inner-city hospitals who treat the majority of America's uninsured population.