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| What Is the Emergency Medical Treatment and Active Labor Act? |

PSC 310W The American congress

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Since emergency medical treatment has been implemented in hospitals, specificities on treatments have become a troublesome topic for hospitals and those in the medical profession. Hospitals used to only treat individuals that could pay for treatments and were selective of who they accepted as patients. After the creation of EMTALA in 1986, hospitals became stricter on reporting violations within the hospital staff, have improved the treatment of patients, and following regulations. Because of this act, the health care system has been improving slowly over the years. However even with EMTALA, many still believe that there can be vast improvements and EMTALA is only the beginning of fixing the health care system. Medical treatment has been a political hot topic in debates and has become more detailed and specified with the creation and enactment of Emergency Medical Treatment and Active Labor Act (EMTALA).

Under the Emergency Medical Treatment and Active Labor Act hospitals that have an emergency department and partake in the Medicare program are required to treat all individuals who enter the emergency department and request help. Thus, the medical staff must give proper medical screening examinations to every patient. If an Emergency Medical Condition (EMC) is found, the hospital is required under EMTALA to stabilize the patients, and if they are in need of transfer they are to be transported once stabilized. Patients cannot be denied based on their citizenship, ability to pay (economic status), insurance status, or race. Women that are in active labor are also covered under EMTALA. However, the act is not only limited to Medicare patients. The act covers all individuals “whether or not the individual is eligible for Medicare” (Joy, 2000) and notwithstanding of any other payer source. Persons that are not protected under this act are individuals who were examined and found not to have an emergency medical condition or after the hospital have stabilized their emergency medical condition.

EMTALA was passed on April 7, 1986 by the 99th Congress and signed by President Ronald Reagan; nonetheless, the act was not effective until August 1, 1986 (). The act was enacted on anecdotal evidence and without hearings, but civilians found out about EMTALA because it was published in the media. At the time Fortney “Pete” Stark, who was the powerful chairman of Subcommittee on Health of the House Ways and Means Committee, introduced the act because he felt that medical care was a federal right. Stark was one of many that noticed the multiple “patient dumping” claims that occurred largely in California and Chicago, Illinois. EMTALA was specifically created to address the “patient dumping” issue and to protect women in active labor. Patient dumping is when a hospital emergency room refuses to provide to uninsured people treatment given to paying and insured patients (Bitterman, 2000). This became a major issue because many people that came into an emergency department were turned away without care even if they had an emergency medical condition. The physicians refused to treat these individuals because they were unable to pay the medical bill, which meant that if the physicians treated them they would be providing free care.

With the Hill-Burton Act of 1946 (more commonly known as the Hospital Survey and Construction Act) added to the constitution under COBRA, communities were provided with better health care facilities; thus, it has been a precursor to EMTALA. The act enabled “federal grants to states for constructing hospitals and required hospitals to provide service for all persons within the area” (Rosenbaum, 2003, p. 591). This meant that there could be more hospitals to provide better treatments to patients since the Hill-Burton Act would relieve other hospitals of overcrowding. Which led to more patients being seen by physicians with shorter periods of waiting time, and the spread of diseases became more under control. Although better and more effective treatments were being provided to the patients with more medical facilities, hospitals found different ways to then turn away patient care.

Due to the lack of care given to patients without insurance, many individuals have suffered permanent injuries or death because they were turned away. An example of patient dumping that triggered supporters of EMTALA was Eugene Barnes. On January 28th 1985, Eugene Barnes entered the Brookside Hospital in San Pablo, California (Bitterman, 2000). He was a 32 year old “habitual drug user” who had received a stab wound to the head and was transferred to San Francisco General Hospital without being stabilized. That was after the attending surgeon at Brookside Hospital made calls to three different hospitals. All refused admittance to Mr. Barnes to be treated before San Francisco General Hospital agreed to have him transferred. Most neurosurgeons refused to perform an operation on him because he did not have insurance or another known method of payment, and at least two surgeons stated they were too tired to perform such a difficult surgery even though Mr. Barnes was in a critical state (Bitterman, 2000). Hours after he had arrived at San Francisco General, Mr. Barnes finally received the needed surgery but by that time he had severe brain damage. On January 31st 1985, Mr. Barnes died from his injuries and lack of immediate care (Bitterman, 2000). However, it was not just patients with injuries that were neglected immediate medical attention.

Women undergoing active labor also need immediate health care and active labor has been a highlighted issue within EMTALA. Active labor is defined by EMTALA as being when a woman enters an emergency medical department while she is experiencing labor contractions. Women in labor cannot be turned away because their pregnant state is considered to be an emergency medical condition and must be stabilized. Birth puts added stress on a woman’s body and if she does not receive the proper medical treatment she is at a higher risk of dying from sepsis. The case of Sharon Ford was critical to providing a section on active labor in EMTALA. In November of 1985, Mrs. Ford was a mother of two and was in labor when arriving to Brookside Hospital’s emergency department (Bitterman, 2000). Because her insurance was not accepted at Brookside she was transferred to Samuel Merritt Hospital where she was confirmed to be in active labor (Bitterman, 2000). She was then transferred again to Highlands General Hospital since they accepted Medicaid where she soon after gave birth to a stillborn (Bitterman, 2000). In both transfers Mrs. Ford had to drive herself to the hospitals to which she was transferred (Bitterman, 2000). Mrs. Ford was denied because of Medicaid HMO and her name was late due to California State being late on delivering medical eligibility list (Bitterman, 2000). On December 10, 1985 Brookside Hospital and Samuel Merritt Hospital were cited for bad treatment (Bitterman, 2000). This case put pressure on the legislature to specify what can be done during certain circumstances.

The language of the act is important because it helps determine what can be done and under specific situations. The case of *Smith v Richmond Memorial Hospital* involved a woman being admitted because of prematurely ruptured membranes, meaning the amniotic fluid breaks early and a woman starts to go into labor. Six days after being admitted both the mother and baby developed emergency conditions that left substantial injuries to both. Smith claimed that the hospital failed to stabilize their EMCs, while the hospital said that she never entered and registered through the emergency department (Bitterman, 2000). Virginia Supreme Court said that the language of the act does not limit applying stabilization and transfer provisions solely to patients that arrive initially at the emergency room (Bitterman, 2000). The court also stated that the act’s purpose is to prevent patient dumping and is not related or dependent on whether a patient came through the emergency room or main entrance of the hospital (Bitterman, 2000). Since hospitals were trying to find ways to neglect their patients by finding loop holes, many state legislatures such as the Virginia Supreme Court, had to step in and provide more clear specifications on treating patients. However, this did not necessarily stop physicians from failing to provide proper care.

In the case of *Burditt v US Department of Health and Human Services (HHS)*, an on-call physician, Dr. Burditt, agreed to examine a pregnant patient. The patient was found to have high blood pressure [hypertension] (Bitterman, 2000). Burditt thought that the patient had exhibited hypertension throughout her pregnancy and knew that hypertension can cause serious problems that can lead to death (Bitterman, 2000). At the time, Burditt transferred the patient to another hospital because he thought that hypertension was beyond his capabilities (Bitterman, 2000). Later Burditt stated that he had the right to “pick and choose his patients.” (Bitterman, 2000) However, under EMTALA the hospital was under contract with EMTALA, and therefore the physician was responsible and regulated under EMTALA obligations (Bitterman, 2000). This case was sent to the Supreme Court because the hospital denied its physician as being under contract with EMTALA since the hospital employs the medical staff (Bitterman, 2000). Nonetheless, hospitals and its physicians were ruled to satisfy the obligations stated in EMTALA since the physician was on-call and employed with the hospital, meaning that the hospital is responsible for medical professionals that are required to help anyone that come into the emergency department (Bitterman, 2000). This case helped establish what “responsible medical staff” is and who is obligated to give medical care when a patient has entered the emergency department of the hospital under EMTALA.

The *Townes v Maria Parham Hospital* case states that the lead doctor once again did not provide necessary help to make sure that the patient was in stable condition. The patient was brought to the hospital with multiple stab wounds. Immediate care was administered and the wounds were cleaned, stitched and bandaged. The doctor also ordered X-rays and lab tests were performed, and an IV treatment was given to reverse metabolic acidosis (when the kidneys aren’t removing enough acid from the body). However, a witness confirmed that the hospital and its staff had disregarded abnormal test results (Joy, 1999, p. 14). Although the Court said the evidence was circumstantial, proper protocols and procedures were not done and the hospital violated the terms of EMTALA. Hospitals are required to give everyone the same Medical Screening Examination (MSE). In this case, the leading physician had done what he thought was the proper examination, but had failed to notice that the patient had pneumothorax and large amounts of blood in his left lung because of negligence. The physician had also failed to re-test the patient’s vital signs, which is important because they help determine if a patient is stabilized. This case questioned what requirements specified for fair treatment of all patients under EMTALA.

However, there were other requirements that needed to be established within EMTALA. Such as what are the requirements to be a part of the EMTALA contract, and who is to enforce these requirements. There were many factors to consider when enforcing the act, like why patients are to be transferred for reasons other than their medical condition. Many possible reasons could be prepaid health insurance, a relationship previously created with a physician that is not a part of the hospital, and eligibility for free medical care at a government hospital, or different public facility. The primary obligations of hospitals are to screen, stabilize or transfer, and accept transfer patients but not to provide the continuing care after screening and stabilization; thus, allowing prepaid health insurance plans. Hospitals can be removed from participation in the Medicare program. However, this would be a financial death sentence because the way that residents are funded is through Medicare. Many patients are also a part of the Medicare program allowing them to get treatments. Hospitals are released from Medicare program *only* if EMTALA has been violated and the hospital fails to correct these violations to satisfy the Health Care Financing Administration (HCFA), so no more violations will transpire (Bitterman, 2000). Hospitals and physicians can be fined up to $50,000 for each violation of EMTALA. In some states there are criminal penalties including license suspension, civil monetary penalties, and civil lawsuits (Bitterman, 2000). Individuals are entitled to sue the hospital or physician for being harmed if EMTALA regulations are violated.

The primary obligations of the hospital, as stated above, are to screen, stabilize or transfer, accept transfer of any patient that enters the emergency department and requests assistance. However, the medical screening examination is not required to give the correct diagnosis; it is only to find if there is an EMC. With the medical screening examination the responsible medical professional is to examine the patient to determine if they have an emergency medical condition within the competency of the hospital’s emergency department. An emergency medical condition is defined as:

“*Acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:*

* *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,*
* *Serious impairment to bodily functions, or*
* *Serious dysfunction of any bodily organ or part.*

*A pregnant woman that is having contractions has an EMC if:*

* *There is inadequate time to effect a safe transfer to another hospital before delivery, or*
* *The transfer may pose a threat to the health or safety of the woman or the unborn child.” (Bitterman, 2000, p. 23)*

Once the medical screening examination is completed by the treating physician, if an emergency medical condition is found, the hospital is to stabilize and if needed, transfer the patient to the best of their ability. In order for stabilization to occur the physician must have actual knowledge of the EMC. Without the actual knowledge of EMC, the physician is not liable for malpractice. Nevertheless, whether stabilizing the patient is futile, unethical, or medically inappropriate does not matter since the standards of care require the physician to treat their patient to the best of their ability. According to government agencies like the HCFA, EMTALA does not apply to those that are already admitted into a hospital. The act has never been applied to inpatients that later develop EMC, and is specific to those that *enter* an emergency department with an EMC and not those already admitted. Nonetheless, the Courts’ view, in most cases is that EMTALA covers inpatients as well as those entering the hospital. The requirements of stabilization (and transfer) under EMTALA are as follows:

* *“Physician or hospital has actual knowledge of EMC*
* *Will apply to patients admitted through emergency department and presenting EMC is stabilized*
* *Inpatients for as long as it takes to stabilize initial presented EMC*
* *New EMCs that come up after patient’s initial EMC is stabilized may not be covered under EMTALA.” (Bitterman, 2000, p. 67)*

Another problem that arises in EMTALA cases is the separate meanings of the word stable. There is stable for transfer, stable for discharge and resolve of the EMC. The different meanings can affect the treatment of the patient. Stabilization for transfer is when a patient is moved from one facility to another for further treatment of EMC (Bitterman, 2000). The patient is expected to leave the current facility and arrive at the second facility without further worsening of their current condition. The transfer only occurs when the current treating physician believes that the second facility has the ability to further treat the patient and the patient is able to arrive safely to the second facility (Bitterman, 2000). The stabilization for discharge is referred to as reasonable clinical confidence that the patient has reached a point where patients continued care could be performed as an outpatient, “given that the patient is given a plan of appropriate follow-up care with discharge instructions” (Bitterman, 2000, p. 75). Hospitals that are accepting transfers are required to accept the transfer if given prior notice that patient will be arriving so that the facility can accommodate and prepare for their arrival (Bitterman, 2000). Under EMTALA the second facility is then responsible to follow the outlined obligations under the act (Bitterman, 2000).

The enforcement of the act was delayed almost 10 years after being enacted because there was no way to ensure that the hospitals were following the obligations outlined in the act. There were also no regulations that stated who was to enforce it and what the punishments would be if the obligations of the act were not followed. Federally, the Department of Health and Human Services (HHS) was split into two groups consisting of the Health Care Financing Administration (HCFA) and Office of Inspector General (OIG). The Health Care Financing Administration is responsible for the federal Medicare program. This branch of HHS determines if a hospital or physician has violated the act and can also end hospitals’ participation in the Medicare program. This loss will end financial reimbursement for medical services given to Medicare patients and from other federally funded programs; Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

HCFA can terminate practically any hospital involved with the Medicare program after investigations are done through their state offices. However, the HCFA rarely terminates hospitals from Medicare program because patients’ access to services in their communities will be affected destructively (Bitterman, 2000). HCFA is more interested in fixing hospitals deficiencies and remaining available to serve patients than removing hospitals from the Medicare program. Of 2500 hospitals investigated, 650 were found to be violators of EMTALA (Bitterman, 2000). Since 1995 there has been a step up in enforcement of EMTALA. This enforcement was created to reinforce HCFA mandated reporting regulation (Bitterman, 2000). In September of 1995 receiving hospitals are required to report hospitals that transfer patients to them in violation of the law (Bitterman, 2000). Hospitals that fail to report on violating hospitals can themselves be dismissed for failure to report incident. These reports require state survey agencies to alert HCFA whenever uncovered or were made known that hospitals were violating EMTALA (Bitterman, 2000). Before these changes states had the option to report violations and it was not a duty to report their discoveries (Bitterman, 2000). Areas that leading in the number of violations are the medical screening requirements, on-call physicians and tertiary hospitals rejecting to accept patients in transfer. (Bitterman, 2000) A way to enforce the act is to give more resources into the education and enforcement of law at the HCFA regional offices.

The Office of the Inspector General (OIG) is responsible with promoting efficiency, effectiveness, integrity of the Health and Human Services programs this includes Medicare. It is important to note that hospitals are directly liable for all violations committed by its medical staff. The OIG can terminate physicians from being part of the Medicare and state programs if they violate EMTALA regulations. However, OIG is involved only if the HCFA investigates and determines a hospital or physician has violated EMTALA. Civil penalties up to $50,000 for hospitals with 100 beds and $25,000 for hospitals with less than 100 beds can be evaluated per violation. Hospitals have paid the largest fines for failure to provide appropriate MSE to managed care patients and failure to accept patients in transfer from another facility, or failure of the on-call physicians to come to the hospital for examining or stabilizing patients in their emergency department. In October of 1994, the HCFA changed policy that required all cases of confirmed EMTALA violations to OIG Office of Civil Fraud and Administrative Adjudication to review all cases. Congress has changed the law, making it much easier for OIG to penalize providers to as before fines were only imposed when a provider “knowingly” violated EMTALA. Now it is easier to prove ordinary negligence standard than to prove physician or hospital actually knew they were violating the law. To help correct and lower these violations more emphasis has been put on greater resources, more funding, more attorneys charged with whittling down older cases and to investigate new one. Surveys are being done to help OIG enforce areas of EMTALA needing improvement.

EMTALA is an amendment under two other acts; Consolidated Omnibus Budget Reconciliation Act and the Social Security Act, for two reasons: treatment of emergency conditions and coverage for payment. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 is an important piece of legislation because the act mandates an insurance program giving some employees the ability to continue health insurance coverage after leaving employment. EMTALA is a part of COBRA under section 9121, “Examination and Treatment for Emergency Medical Conditions and Women in Active Labor Act” (Bitterman, 2000). COBRA includes emergency room treatment under EMTALA and also covers reimbursement to hospitals. The Secretary of Health and Human Services has a year to repay the hospitals for their medical expenses starting at the beginning of the fiscal year; this reimbursement covers goods, services comprising routine, ancillary, special care unit inpatient hospital services (U.S. GPO, 1985). Medical education is also covered by the Secretary and is to be an added amount to the reimbursement. Whether the interns and residents are employees of the hospital they aren’t separate costs of the amendment. These are also a part of the Social Security Act amendments.

The Social Security Act was added because participating hospitals within the Medicare Program are subject to EMTALA regulations. Patients that are covered have paid coverage under Medicare, Medicaid and are considered under the Medicare program. Under section 1867, EMTALA applies to hospitals with emergency department which are a part of the Medicare program (Joy, 1999). Under Medicare hospital requirements whether a person is able or not for benefits under this title, a hospital must provide an appropriate medical screening examination within hospitals emergency department capabilities. Stabilization of an individual is requirement of hospital if the hospital determines an emergency condition or active labor has occurred. Refusal of treatment or transfer cannot be avoided because these requirements must be met by the hospital. Transfer of patient can occur with tertiary facility only if facility has available room and competent staff for treatment. Once the accepting facility has agreed to accept the patient, they must give proper treatment for the EMC. The receiving hospital must obtain proper medical records of patient from previous hospital (from time that EMC was diagnosed to time of transfer). Transferring of patients must be completed through proper staff and transportation including necessary medical appropriate life support measures throughout transfer. If a hospital knowingly and willfully fails to meet requirements they are subject to termination, suspension of agreement and civil monetary penalties [paying civil money penalty] (U.S. GPO, 1985).

Throughout its existence, EMTALA has had changes made to make it more obvious for hospitals and physicians on what the regulations are. These changes have helped EMTALA become more effective to those it protects and also become more unyielding on hospitals that are a part of the Medicare program. Changes that were made were to have emergency rooms have an on-call physician, medical screening examination, stabilization, transfer specifications. The definition of a responsible physician has been specified. All these changes have made EMTALA have much more of an impact on the health care community.

With the changes to the act, hospitals are now required to have emergency rooms with on-call physicians in order to determine EMC, help stabilize patients that are accepted or transferred from other hospitals. In the case of Tom Holman who was shot in the head was transferred because the emergency physician was not able to get a neurosurgeon to operate on him. If a surgeon had operated on him at the time of determining how severe the injury was, Mr. Holman would not have had brain damage. The amendment is to help patients like Mr. Holman so that patients can be stabilized and cared for at any time of day. Without on-call physicians, many people would be without emergency care, and women would not be able to give birth at odd hours of the night.

Hospitals are now forbidden from postponing MSE, stabilizing treatment, or specialized treatment at accepting facilities due to patients insurance status, economic status. EMTALA was created for this very reason and having this defined has cleared up issues that hospitals had because the wording within the act was vague and broad. By not postponing treatments to patients with EMC, it is less likely that they will have permanent damage to their bodies. This was added because many cases where patient dumping was involved there was also the lack of care given. This addition also makes it a requirement for hospitals and physicians to do all they can to assist their patient in becoming stable or fixing their EMC.

The 1989 amendment had redefined “responsible physician” as “any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician that is on-call for the care of such an individual” (Bitterman, 2000, p. 19). This definition means that *any* physician that treats patients in Medicare participating hospitals are issued to legal obligations of EMTALA. Within the case of *Burditt v US Department of Health and Human Services,* this was an issue that had caused medical problems with the patient because no physician would help until the third physician was called to come in. With the medical staff of a hospital being labeled as “responsible” they are legally liable for any harm done to patients. They have the ability to help individuals that ask for it and are in need of it.

When an investigation has taken place, the hospital is to be notified when it begins and when it ends. This is known as the “EMTALA Regulatory Improvement Act of 2003.” When ending a hospitals participation in Medicare program it was added that “except in cases that delaying would jeopardize health or safety of individual, a review by the Secretary will determine as part of termination of hospitals participation under this title in violating appropriate MSE, stabilizing treatment, or appropriate transfer required by this section and will give five days for review. A copy of the report is given to the hospital or physician with confidentiality requirements imposed by organization.” (H.R. 1382, Section 2)

A part of the amendment is creating a special Advisory Group to review issues related EMTALA and applying it. Nineteen members are to be within this group; Administrator of the Centers for Medicare & Medicaid Services, Inspector General of Dept. of HHS. Four representatives of the hospital; one public hospital with experience of applying EMTALA and two that haven’t been cited for violating EMTALA, seven practicing physicians from emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or pediatric subspecialty, obstetrics-gynecology, and psychology. There cannot be more than one physician form any area. There must be two representatives of patients, two staffers involved with EMTALA investigations from different field offices of Centers for Medicare & Medicaid Services, one from the state survey office that is knowledgeable of EMTALA investigations and one from a peer review organization. The members of the Advisory Group are to elect a chairman for the life of the group. The group is to meet twice a year and to end twenty months after the first meeting date. Responsibilities of this advisory group are to

* Review EMTALA regulations
* Give advice and recommendations about regulations and relationship to hospital and physicians to the Secretary
* Take comments and recommendations from hospitals, physicians, and the public about applying regulations
* Advisory group can disseminate information on applying regulations to hospitals, physicians and the public. (H.R. 1382, section 3)

The final change made to EMTALA was in 2003 and answered the question if EMTALA applies to hospital inpatients. The case of *Roberts v Galen of Virginia (1999)* helped make this decision. EMTALA does not apply to hospital inpatients, those individuals that are already under the care of the hospital before being found to have an EMC even if an individual was admitted through the emergency department, and EMTALA was initiated and stayed un-stabilized after becoming an inpatient. EMTALA does not apply to stabilized inpatients even if they become unstable because they are covered by multiple Medicare conditions of participation. It was also clarified that EMTALA obligations for hospitals ends when the individual is stabilized or the hospital admits individual with an EMC as an inpatient to give stabilizing treatment. (Federal Register, p. 5214)

The significance of the Emergency Medical Treatment and Active Labor Act is that it created a better health care system for the uninsured. Creating a better way to give health services can improve a community’s health and adds prestige to the health care industry. With the improvements toward health care many cannot be rejected or go without help. Since EMTALA is a part of the Social Security Act it covers helping patients on Medicare and other federal programs. By having patients being unable to be denied medical treatment based on economic status makes it easier for them to get the treatment they deserve and need. As Senator Durenburger said,

“All Americans, rich or poor, deserve access to quality health care. This question of access should be the government’s responsibility at the federal, state, and local levels. We cannot and should not expect hospitals to be this nation’s National Health Service.” (Joy, 1999, p. 4)

Having the ability to receive emergency health care when unable to pay for it right on the spot or have coverage under insurance, is important to many because it gives them a sense of security. This sense of security helps many people within the United States. The act has its benefits like giving care to those that ask and need it, covers those on Medicare which itself is a stressed system. These benefits have helped save women in labor bringing their children into this world, it has helped people in many types of accidents survive and has also attacked the issue of patient dumping which has lowered since the creation of EMTALA.

Along with the positives, EMTALA has negatives such as cost pressures on hospitals. Many bills are not compensated for emergency care. This causes health care costs to go up on procedures and regular examinations. These cost pressures have caused facilities to close and also consolidate – emergency rooms have become overcrowded and EMTALA is to blame. Emergency departments have dropped as more people have been visiting the emergency rooms. With the closing of facilities many communities are unable to give service to those in need of it. EMTALA was created to help those individuals that are uninsured, unable to pay for medical treatments but with more pressure put on hospitals the ability to help those that need it is hindered. There need to be regulations and obligations to every law but when the law prevents what it originally was created to fix causes more burdens than solutions. Although the program is now stressed and incomplete it is doing its job in creating health care for those otherwise unable to get it.

Enacting EMTALA has improved medical care, treatment of patients, and improved regulations within hospitals. With updated hospital regulations, states have now passed EMTALA-like laws. These laws help patients get treatment while also penalizing hospitals or physicians with civil money penalties, terminate their involvement in the Medicare program, when they violate EMTALA. States that have passed these laws are; California, Florida, Georgia, Illinois, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Ohio, Oregon, Tennessee, Texas, Washington, West Virginia, Wisconsin, Wyoming. There cannot be a coincidence that so many states feel that medical care is a right. EMTALA is a significant act because it provides the basis of emergency medical treatment for citizens. Because EMTALA established that medical care is a right and has provided a stronghold for why medical should be granted to everyone, it has remained a political hot topic to this day.

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