INTRODUCTION

The Emergency Medical Treatment & Labor Act of 1986[^1] (a.k.a. EMTALA) is a federal legislative solution to problems created by the financial pressures initially brought about by managed care and Medicare Diagnostic Related Groups (DRGs) in the late 1970’s and early 1980’s. Hospitals responded to this fundamental change in healthcare funding by attempting to divert indigent patients to public (county) hospitals and through strict compliance with managed care demands for transfer of patients to “contracted” facilities. Unfortunately, this practice led to inevitable disparity in hospital care and emergency care in particular. Several examples of untoward outcomes and even deaths from this practice soon emerged. As a result, EMTALA was enacted to eliminate financial and other types of discrimination with respect to hospital emergency care. No funding has ever been appropriated for EMTALA despite its obvious and escalating cost to healthcare providers. Instead, to implement this provision, Congress made EMTALA part of the Medicare Certificate of Participation Agreement such that hospitals “voluntarily” agree to comply with and bear the cost of EMTALA by virtue of their participation in Medicare.

WHAT IS EMTALA?

EMTALA has two principle requirements for Medicare participating hospitals:

1) Any individual requesting, must receive a “medical screening examination” to determine if an “emergency medical condition” exists.

2) If an “emergency medical condition” is identified, a hospital must provide stabilizing treatment within its capability or accomplish an “appropriate” transfer with the consent of the patient and a physician certification that the benefits of the transfer are outweighed by the risks.

CFR 42 - Sec. 489.24 Special responsibilities of Medicare hospitals in emergency cases.
(c) Necessary stabilizing treatment for emergency medical conditions—
(1) General. If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--
(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition; or
(ii) For transfer of the individual to another medical facility in accordance with paragraph (d) of this section.

(d) Restricting transfer until the individual is stabilized—
(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless--
(i) The transfer is an appropriate transfer (within the meaning of paragraph (d)(2) of this section); and
(ii) (A) The individual (or a legally responsible person acting on the individual’s behalf) requests the transfer, after being informed of the hospital’s obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;
(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

EMTALA’s original intent allowed the continued practice of transferring indigent and managed care patients to other facilities, but only after the patient had been evaluated and determined to be “safe” for such transfer. However, in practice (in large part due to aggressive CMS enforcement) this practice has been virtually eliminated due to the inherent increased regulatory and civil liability that EMTALA has created. Furthermore, public hospitals and hospitals contracted with managed care (often capitated such that they receive no additional compensation), soon began refusing to accept these “financially” motivated transfers. Eventually in many states, public hospitals and clinics (with the mission to provide indigent care) were closed or “privatized” because EMTALA removed the principle reason for their existence (i.e. patients would otherwise have no resource for medical care). In effect, EMTALA made every Medicare participating hospital into a “public” hospital with an unfunded federal mandate to provide comprehensive healthcare irrespective of the patient’s ability to pay or intent of the patient or their healthcare plan to pay for services rendered. Despite this significant financial burden, Medicare reimbursements decreased throughout the 1990’s, disproportionate share funding was eliminated or not readjusted to account for the shift in where indigent care was being delivered, and local/county governments exited the healthcare business. In essence, EMTALA allowed America to avoid dealing with the issue of uncompensated healthcare and the uninsured for more than 15 years by transferring that responsibility to healthcare providers. We are now paying the price for that “policy” as evidenced by shortages throughout the healthcare industry including nurses, physician specialists, hospital beds, EMS, certain medications, emergency department (ED) crowding, etc.

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2 A recent example was the closure of DC General Hospital in Washington, DC
3 Eisenberg D. Critical Condition. Time Magazine. Jan 31, 2000; p52-54
4 Stapleton S. Where’s the nurse? Am Med News. Jun 18, 2001; pg 30-31
7 Gately E: Rural/Metro reports $101.3 million loss for fiscal year. Arizona East Valley Tribune; Sept 22, 2000, Page B2
IMPACT of EMTALA

It has taken more than a decade for the full impact of EMTALA to be realized and it is only now being documented\textsuperscript{10}. By default, EMTALA became America’s national healthcare policy and thrust the financial burden for indigent care upon hospital providers (including for-profit and non-profit hospitals, emergency physicians, and on-call physician specialists). EMTALA has severely limited provider’s ability to obtain appropriate compensation for services even from insured patients due interference with the collection of copays/deductibles and fostering managed care payment denials due to prohibition of prior-authorization and the functional elimination of “financial” transfers. Despite record economic expansion during the 1990’s, this, among other issues, has created what amounts to a “healthcare recession” (contraction of the healthcare market and declining revenues in the face of increases costs of labor and despite an increasing need). The result today is a lack of essential healthcare services (such as inpatient hospital beds, emergency services including EMS, on-call specialists, and severe ED crowding) in many regions of the country\textsuperscript{11}.

As currently enforced by CMS, EMTALA prohibits inquiring or requesting payment for hospital emergency services until care is essentially completed. Functionally, this has removed the principle motivation for people to obtain/maintain health insurance (i.e. without it you might be sent to the “county” hospital) and for patients to seek primary care in alternative settings (i.e. family doctor’s office) where they must pay upfront for care. EMTALA has simply changed the healthcare financing equation.

Specific EMTALA Implications:

The GAO EMTALA Study [Part I – published June 2001] commissioned by Congress illustrated many issues. Specific issues are discussed in detail in a document the Arizona College of Emergency Physicians provided to the GAO for that report. These items are summarized below and the full document attached.

EMTALA EXPANSION\textsuperscript{12}

EMTALA is now so complex that textbooks have been written and EMTALA seminars are being held on a regular basis. The worst expansion has occurred through administrative case law & now more frequently through civil malpractice actions. EMTALA has become a functional “national malpractice act” and serves to bolster even the weakest malpractice case by invoking a statute with such dire consequences that many hospitals and physicians settle simply because of the threat of an EMTALA action.

CMS, in over aggressive enforcement, has also been using EMTALA as “quality of care” regulation. Complicating this fact is that there is no requirement for peer review prior to citation even if the allegation is based upon a quality of care concern. The statute also creates a “private cause of action” that has led to an explosion of civil malpractice lawsuits even though CMS may determine that there was no EMTALA violation (eg. Coleman v. Deno, Louisiana Court of Appeals, 2001 & Arrington v. Wong, 2001 U.S. App. LEXIS 783 - 9th Cir. Jan. 22, 2001)

Finally, just the fear of an investigation and citation due to a “guilty unless you can prove yourself innocent” approach in EMTALA tends to cause so much fear that “over-compliance” is often practiced a way to assure staying out of trouble.

\textsuperscript{10} Taylor TB. Threats to the Health Care Safety Net. Academic Emergency Medicine November 2001;Vol. 8, #11, pp.1080-87
\textsuperscript{11} Taylor TB. Emergency Services Crisis of 2000—The Arizona Experience. Academic Emergency Medicine November 2001;Vol. 8, #11, pp.1107-08
INCREASED COST OF EMERGENCY CARE

Regulatory compliance; staff time necessary to complete EMTALA documentation requirements (i.e. detailed ED logs, multiple types of forms); managed care payment denials (for treat & release and for admitted patients not transferred to a contracted hospital); lost opportunity to obtain demographic information (thought by some to be prohibited by EMTALA until completion of the MSE); increase regulatory and malpractice liability exposure; EMTALA education; and defense of EMTALA allegations all cost money and the list goes on and on. But even more poignant, is that EMTALA has turned a 2 minute question at triage “does this need stitches”, into a 4 hour wait to see a doctor and a $200 charge to hear, “no it doesn’t”. The aggressive way EMTALA has been enforced by CMS has disrupted tried & true standards in medical care to the point of, at times, being counterproductive.

REDUCED AVAILABLE SERVICES

EMTALA has changed the very purpose of the ED, by making it the healthcare resource of last resort by an unfunded federal mandate for anyone and everyone, including non-citizens. In my opinion, it is largely responsible for the ED crowding crisis we now face.

Hospitals that continue to provide a full range of specialized services are at increasing risk as other hospitals eliminate services or specialize due to budgetary constraints or a lack of available medical staff. Some hospitals have eliminated certain diagnostic test either entirely or made them available only during “business hours”. Since the ED is the biggest user of such services after hours and weekends, these hospitals can no longer afford to provide certain services for the level of reimbursement received.

EMTALA has also had a dramatic effect on the medical staff. Virtually every hospital now has some difficulty obtaining willing specialists (e.g. hand surgeons, ENT, ophthalmologists, etc.) to take ED call. Doctors are now doing everything possible to avoid ED call even to the point of resigning hospital privileges altogether and EMTALA is often cited as the final “straw” in such decisions. In today’s healthcare market, doctors no longer need the ED “business” and, increasingly, do not even need the hospital due the availability of enhanced outpatient services.

PUBLIC PERCEPTION

EMTALA has changed the public perception of the ED: Many patients now know they cannot be refused care and choose the ED instead of seeking routine care in a doctor’s office. Even insured patients come to the ED to avoid paying a co-pay at their doctor’s office (or urgent care) or because they tend to get free medication and “immediate results” in the ED. Local physicians now use the ED as their “admitting office” because once patients are in the ED managed care plans have a difficult time denying the admission and there is much less paper work for the doctor’s office personnel. The word is out that “free” care is available in American EDs and many border hospitals routinely provide uncompensated healthcare for foreign nationals. Even primary care doctors have learned to send their uninsured patients to the ED instead of trying to provide care from a variety of other sources. Local urgent cares often send uninsured patients because, “if they stay here it’s going to cost them a lot of money”.
EMTALA HISTORY & IMPACT SUMMARY

The federal government recognized the need for an “emergency care” safety net in the mid 1980’s when hospitals, due to increasing financial pressures, began refusing to provide emergency care to even unstable indigent and managed care patients. This unfortunate situation led to the enactment of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986, which to this day is the only federally mandated safety net healthcare in America and an unfunded mandate at that.

Mandates aside, America chose the free-enterprise system to fund healthcare, but government intrusion continues to alter the fundamental principles of this “free enterprise”. EMTALA is perhaps the most glaring example of this intrusion and has had serious effects on emergency services directly and indirectly on virtually every other aspects of healthcare. Fully implemented in 1994 by federal regulation, EMTALA has taken more than a decade for its full impact to be realized. EMTALA allowed local county governments to abdicate their responsibility for indigent healthcare and instead thrust this responsibility upon an often woefully inadequate Medicaid system. In effect, EMTALA has become a federal mandate for hospitals and physicians to provide healthcare to everyone (even if not an American citizen) irrespective of ability to pay (or intention of paying even if they have the ability) and thereby alleviating local government and insurance plans of that responsibility. With the ensuing closure or “privatization” of public hospitals and clinics, this left the private sector to grapple with the indigent, infirm, and undocumented. At the same time, through managed care and other funding mechanisms such as Medicare Diagnostic Related Groups (DRGs) and now the Ambulatory Payment Classification System (APCs), America allowed the insurance industry to eliminate the traditional insurance-based “cost shifting” funding for indigent care. Capital for expansion vanished in the 1990’s and dramatic cost cutting made hospitals very difficult places to work and at times more perilous for patients. The federally mandated “EMTALA care” has inadvertently encouraged reliance upon hospital EDs as the principle and perhaps sole remaining safety net resource in America and for bordering countries.

Ultimately EMTALA and associated factors created a “healthcare recession” in many parts of the country throughout the 1990s and into this decade. If these are the problems, then what are the solutions?

SOLUTIONS

Clearly EMTALA has served a useful purpose over its 15-year reign. It has prevented people from indiscriminately being turned away from hospital EDs and suffering as a result. It has allowed America to ignore the plight of the uninsured and foreign national healthcare issues. For a time it assured that the full services of a hospital, including on-call specialty physicians, would be available to care for anyone and everyone. But EMTALA is now beginning to fail and economic pressures have steered healthcare markets in new directions. EMTALA is no longer as effective and in some ways even counterproductive.

Hospitals (particularly “specialty” hospitals) have limited their services by “specializing” or concentrating only on profitable services to the exclusion of general hospital and emergency care. Specialty physicians have limited their practices or opened outpatient centers in an overt attempt to avoid EMTALA. Specialty physicians who cannot practice without the hospital (e.g. general surgeons, neurosurgeons, etc.) are demanding payment to be on-call &/or guaranteed billings. Emergency physicians are struggling to keep up with increasing demand for ED services in the face of declining resources and shortages of even essential services. Experienced ED nurses are leaving in unprecedented numbers. Lawsuits based on the increase liability created by EMTALA promises to perhaps bankrupt the remaining providers.

To follow are regulatory and legislative solutions to help mitigate the untoward effects of EMTALA. It must be clearly understood that until the issue of funding and coordination of care is resolved, EMTALA, in some form or another, must be maintained. To do otherwise could potentially result in patients suffering or even dieing in the street.
SUGGESTION #1: Funding Mechanism for EMTALA (and all other healthcare):

While this may seem a daunting, if not an impossible task, the Arizona College of Emergency Physicians in the document, “Proposed Solution for Healthcare Funding in America”, proposes three innovative mechanisms to accomplish EMTALA funding with only an incremental cost.

1) A “low cost government healthcare loan program” to address periodic healthcare for anyone without other means to afford the care necessary. (See full explanation in the above named document)

2) A national standard for Medicaid eligibility similar to the SCHIP program (currently at 200% FPL).

3) “Deemed eligibility” (similar to the SCHIP program) so that those eligible can be assured of first day coverage when needed.

Implementing these three concepts could achieve virtual universal healthcare coverage at an incremental cost; yet hold individuals responsible for their healthcare expenses and averting yet another entitlement. This plan would also go a long way toward resolving the abuse of the ED for primary care since people would be held responsible for the bill and the program would also apply to outpatient care. Family doctors would be able to see uninsured patients in their office without worrying about payment issues.

SUGGESTION #2: EMTALA & Managed Care:

If a patient has insurance, the receiving facility (not necessarily a hospital or higher level of care) agrees to accept the patient in transfer, the patient signs an informed consent for transfer, and is willing to take whatever risks are associated with the transfer whether they are “stable” or not, then the EMTALA obligation should be considered to have been met. Many of the basic tenants of managed care are in direct conflict with EMTALA. Yet, discussing how one can obtain coverage for healthcare has become a necessity under managed care. EMTALA tends to subvert these discussions leading to increased cost for patients, hospitals, and health plans.

SUGGESTION #3: The EMTALA Mandatory Reporting Requirement:

The mandatory reporting provision should be eliminated and be voluntary under all circumstances. This provision was added in the 1994 CFRs and has had a profound effect on EMTALA. It essentially prohibits the discretion of hospitals in reporting EMTALA violations and forces them to report everything, even if only a suspicion. This has lead to a significant number of frivolous reports and bogged down the system to the point that the true EMTALA cases cannot be dealt with expeditiously. It has also created a major cost for hospitals that now must constantly investigate and defend themselves in cases that turn out to be trivial or simple misunderstandings. This has also created a culture of mistrust among hospitals that might otherwise be able to work together to serve the community and solve these problems together. EMTALA should primarily be “complaint” driven.

SUGGESTION #4: Clear Definitions:

The examining physician should have the ultimate authority to determine (based on available information) which patient has an “Emergency Medical Condition” (EMC) and for those who do have an EMC which ones are “stable” for transfer or discharge. An EMTALA citation should only be allowed if it can be shown by a preponderance of the evidence that the physician/hospital was below the community standard of care in arriving at those conclusions. Final outcome or subsequent information should have no bearing on the case. There have been many articles and book chapters written on what “Emergency Medical Condition (EMC)”, “Stable”, and “Medical Screening Examination (MSE)” mean in the context of EMTALA. Nevertheless, these definitions remain elusive because each individual case is decided after the fact (when all subsequent information is known) and are often reviewed by PEER physicians who have limited knowledge of EMTALA.
SUGGESTION #5: EMTALA is Not a Quality of Care Regulation:
EMTALA should only be used as an anti-discrimination regulation and thus returned to its original intent. There are many examples of this “abuse” of EMTALA. In modern healthcare, quality of care is dealt with in many other ways and in a constructive rather than destructive manner. EMTALA by its very nature is destructive and tends to subvert the openness necessary to improve quality.

SUGGESTION #6: Limit the Use of EMTALA in Civil Malpractice
The provision [42-Sec. 1395dd.(d)(2)(A)] that creates a private cause of action should be eliminated and a prohibition against EMTALA as a private cause of action should be added.

Title 42- Sec. 1395dd. Examination and treatment for emergency medical conditions and women in labor
(d) Enforcement
(2) Civil enforcement
(A) Personal harm
Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

As currently written, EMTALA has the potential to bring emergency care to its knees in civil liability. This serves no purpose except to further burden hospitals and physicians with legal wrangling. Medical malpractice should be restricted to state courts where local communities can decide what is right. EMTALA opens up a whole new realm of malpractice in already over burdened federal courts. There are many examples of how “EMTALA malpractice” has led to peculiar outcomes in federal court.

SUGGESTION #7: Safe Harbors
Clear safe harbors need to be established so that hospitals do not find themselves constantly readjusting based on the latest CMS proposed rule or court case. “Fear” of an investigation is perhaps one of the most damaging untoward consequences of EMTALA and has significantly added to the “defensive medicine” problem by encouraging excessive ordering of tests/consults, admitting questionable patients, and in transfer avoidance even when it might be appropriate. Clear regulation that cannot be misconstrued or repurposed by administrative or civil courts is imperative. There are several examples of this in case law. For example we currently do not know when EMTALA begins and when it ends, due to court cases extending EMTALA to ambulances en route and to inpatients.

SUGGESTION #8: Reasonable Procedures in Consideration of Common Medical Practice
EMTALA should conform to common medical practice, rather than forcing medicine to change to EMTALA’s “way of doing things”. There are numerous examples of how EMTALA has not only changed, but uprooted medical care. In many settings it has relegated nurses to mere technicians and stripped them of any medical decision making. For example, many patients can be determined not to have an EMC by a nurse at ED triage. EMTALA has expressly prohibited this decades long practice and resulted in longer ED waits and increased cost for no demonstrable benefit. Somewhere in the EMTALA formulation, it was determined that only a physician could definitively determine if someone was sick or not. Nurses perform this function in virtually every other medical setting (e.g. nurse advice phone lines) and to say that somehow they are not capable of doing so in the ED at triage is ludicrous.

SUGGESTION #9: Service Availability
Only require that hospitals participate in a community-wide service rather than being all things to all patients at all times. One of the tenets of EMTALA has been that whatever is available to inpatients must also be available to ED patients 24 hours per day. While noble in its pronouncement, in many instances it is impractical and at times creates perverse situations. A plan to deal with such situations should be sufficient and would encourage cooperation within communities for coordination of services that might otherwise be impractical for every hospital to have available 24/7.
SUGGESTION #10: EMTALA Administrative Cost
Additional reimbursement must be added to Medicare &/or other funding mechanism to account for the cost of EMTALA. EMTALA education and compliance are expensive and do not translate into better patient care. Nevertheless, hospitals are forced to do this and to divert funds that might otherwise be available to improve or enhance medical services.

SUGGESTION #11: Innocent Unless Proven Guilty
Unless there is compelling evidence of immediate impending harm to patients, CMS should be required to prove their case before citing hospitals for a violation. Investigations should be limited in scope and not become “fishing expeditions”. Increasingly, there are “Roseanne Roseanadana” moments where after a lengthy investigation and multiple citations, information is discovered that exonerates the hospital, and CMS says, “never mind”. Allegations should be made, proof given and a judge should decide upon whether to impose a citation unless the parties enter into a consent decree. Also, the investigation should be limited in scope and only broadened under strict criteria, such as evidence of fraud.

SUGGESTION #12: Clear Guidance on Providing Information to Patients
There must be clear guidance, based in reality, as to what patients may be told prior to the MSE. Patients are often alienated because there is no clear guidance as to what can be said and when. Telling a patient the wait is 5 hours to see a doctor or how much they can expect to pay for the visit have been interpreted as possible EMTALA violations. Obviously this important information anyone might want to know and refusing to provide this information sometimes makes patients indignant.

SUGGESTION #13: Conflict with State Law or Community-Wide Programs
As a federal statute, EMTALA may supercede state law, but reasonable adjustments must be made to accommodate local variances. There are a variety of examples where EMTALA conflicts with state law. Many involve behavioral health and involuntary commitment procedures. Others involve established community-wide plans to deal with specialized care such as sexual assault or behavioral health. It has even been suggested that allowing a police officer to remove a patient under arrest from the ED prior to completing the MSE could be a violation. The untoward situations are numerous and there must be some protection for providers often caught in the middle.

SUGGESTION #14: Abuse of the ED Due to EMTALA:
Providers must have some protection from patients who show a pattern of abuse by “gaming the system” or who refuse to provide accurate basic demographic information. This is a burgeoning untoward consequence of EMTALA. Increasingly foreign nationals are using EMTALA as a way to access healthcare in America. While this has also been true of American citizens, providers do not have the same legal options available to deal with the undocumented. It seem ludicrous for hospitals to be forced to extend services (including narcotic pain medications and invasive procedures) to people who have no requirement to provide even a single form of identification, a legal social security number, or accurate contact information. Strict interpretation of EMTALA prohibits a hospital from refusing care to someone even if they refuse to provide their name.

SUGGESTION #14: On-call Specialists
Liability protection, compensation, and safe harbors are necessary as a minimum to rebuild our specialty rosters at most hospitals. This area may be perhaps the most difficult challenge and it does not entirely revolve around EMTALA. Perhaps without EMTALA we would have lost most of our on-call coverage several years ago. Specialists are now being forced to take call as a condition of medical staff membership. Other issues involve being on call at one hospital, but being scheduled to do procedures all day at another. How can this be balanced? More and more doctors are simply resigning privileges at smaller hospitals to avoid this conflict and leaving these hospitals without any coverage. Solutions for the on-call crisis require a coordinated effort and EMTALA is a big piece of that effort.
SUGGESTION #15: Physician EMTALA Liability Exposure

It is not reasonable for individual physicians to assume equal, if not more, liability than hospitals with regard to EMTALA. Physicians have equal fines ($50k/violation) and consequences (Medicare decertification, malpractice risk, etc.) as hospital with regard to EMTALA. At the same time, physicians clearly do not have the same resources as hospitals. Additional liability coverage must be obtained to cover an EMTALA action against a physician. Is it any wonder doctors want to avoid being involved with anything (i.e. on-call duty) associated with EMTALA?

SUGGESTION #16: Complexity

As EMTALA is reorganized we should keep simplicity in mind. Human nature dictates that people, especially on-call specialists, will avoid things they cannot understand. Although many of the suggestions above could resolve much of the confusion and complexity surrounding EMTALA, a concerted effort must be made to ground the law in reality and with consideration of common practices. If it does not make sense at 3am on the weekend, perhaps it should be revised.

SUGGESTION #17: Managed Care

Require managed care to provide coverage for EMTALA services using an “EMTALA-Based Standard”. Perhaps one of the greatest failings of the original EMTALA statute was the lack of attention paid to the realities of managed care. This fact has led to contentious fighting and abuses by managed care for many years. At least one partial solution has been forwarded in several states and at the federal level in the form of the “Prudent Layperson Standard” for an emergency. Unfortunately this concept does not address the real issue. EMTALA requires certain services irrespective of prudence and prohibits providers from insisting upon payment or in seeking prior-authorization from managed care until after the fact. Using an “EMTALA-Based Standard” is more practical. Such a law was passed in Arizona in 1996 (SB1286–Access to Emergency Health Care, available at www.azcep.org) with the cooperation of the state’s managed care industry. Although other issue remain, with respect to EMTALA, this law has been very effective.

SUGGESTION #18: Foreign Nationals

Provide a basic funding mechanism for foreign nationals that access healthcare under the guise of EMTALA. In 1997, immigrants made up about 10% of the US population; however they accounted for 20% of the uninsured.13 This special group of healthcare users includes foreign nationals that enter the American healthcare system by misfortune or by a covert attempt to receive healthcare is the U.S. rather than in their native country. The reasons for this phenomenon are many, but the fact remains that this special group remains the responsibility of the federal government and requires a separate system to manage and provide appropriate compensation to providers. Border issues and international relations will often dictate how such patients are managed. We should not turn our backs on those in need, but at the same time we must find ways to deliver such care without overburdening our healthcare system and making services unavailable to our own citizens. Our border hospitals can no longer afford for this issue to be ignored.

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