
EMTALA'S IMPACT ON PATIENTS' RIGHTS IN COLORADO EMERGENCY ROOMS

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During the Reagan Administration, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) to crack down on hospital emergency departments (EDs) that were refusing to treat poor patients. The Act prohibited EDs from screening patients based on their ability to pay. Thirty years later, EDs have used provisions of the Act to dodge questions from curious patients about their treatment options and costs. In 2016, two Democrats introduced a bill into the Colorado General Assembly that would provide a warning to emergency department patients without an emergency condition that an urgent care center or a primary care physician may be better options for continuing treatment. A panel of Republicans blocked the bill with the support of the health care industry, which claimed, erroneously, that it violated EMTALA. Yet price transparency and health care industry accountability are not partisan issues: in March 2017, Republican Members of the U.S. Congress introduced bills amending EMTALA that recognize these very points. This acknowledgement, plus the critical need to provide greater consumer transparency, provides a new impetus to introduce and pass this Comment's proposed Pre-Screen Notice in the Colorado General Assembly. In contrast to the blocked bill's simple warning, the Pre-Screen Notice encourages a substantive relationship between physician and patient.

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INTRODUCTION

Colorado patients have many choices when seeking medical care. Those who have insurance can head to their primary care or in-network physician in addition to an urgent care clinic, a hospital emergency department, or a free-standing emergency department. Emergency departments

(EDs) are ideally reserved for life-threatening emergencies.¹ However, a substantial number of Coloradans are choosing the ED for treatment of non-emergency conditions, accounting for about forty percent of ED use in Colorado.² In today's need-it-now culture, larger numbers of Coloradans are choosing EDs for their 24/7 drop-in availability and convenience.³

A patient's choice in care setting likely won't affect the quality of her immediate treatment, but it can dramatically impact its cost.⁴ Treatment for a non-emergency medical condition at an ED can cost up to ten times more than at an urgent care facility, but patients are often oblivious to this difference.⁵

The increased demand and higher prices have prompted the health care industry to build free-standing emergency departments (FSEDs).⁶ These new facilities are built separately from hospitals and are located in convenient, unconventional locations like shopping centers, where urgent care facilities are also common.⁷ In Colorado, the number of FSEDs tripled between 2014 and 2016.⁸ While an increase in FSEDs could be viewed positively, as it has made on-demand care more accessible, the boom raises concerns about

1. *Emergency Room vs. Urgent Care: Where Should I Go?*, CIGNA MED. GROUP (last visited Dec. 18, 2016), <https://www.cigna.com/emgaz/urgent-care/emergency-room-vs-urgent-care> [<https://perma.cc/DPL7-PEWK>].

2. COLO. HEALTH INST., COLORADO HEALTH ACCESS SURVEY: A NEW DAY IN COLORADO 25 (2015).

3. *Id.* ("About one of five (21.7 percent) Coloradans reported visiting the ED at least once in the past year, an increase from 19.5 percent in 2013.")

4. Bridgett Weaver, *The Health Care Paradox: Northern Colorado Companies Build ERs to Meet Demand; Too Many Patients Using ER as Primary Care*, GREELEY TRIB. (Feb. 24, 2016), <http://www.greeleytribune.com/news/business/the-health-care-paradox-northern-colorado-companies-build-ers-to-meet-demand-too-many-patients-using-er-as-primary-care/> [<https://perma.cc/Z4T3-HK6V>].

5. CTR. FOR IMPROVING VALUE IN HEALTH CARE, UTILIZATION SPOT ANALYSIS: FREE STANDING EMERGENCY DEPARTMENTS 2 (2016) [hereinafter CIVHC FSEDs]. Treating bronchitis in Colorado will cost approximately \$980 at an ED or \$100 at an urgent care center. *Id.* The cost of treating a urinary tract infection is likewise ten times more expensive at an ED than at an urgent care. *Id.*

6. David Olinger, *Free-standing ERs Abound in Affluent Colorado Neighborhoods*, DENVER POST (Sept. 24, 2015, 2:56 PM), <http://www.denverpost.com/2015/09/24/free-standing-ers-abound-in-affluent-colorado-neighborhoods/> [<https://perma.cc/B5PH-XYRK>].

7. *Id.*

8. CIVHC FSEDs, *supra* note 5.

affordability, transparency, and disclosure. FSEDs share EDs' higher pricing, but consumers are more likely to mistake them for traditional urgent care clinics.

One Coloradan with a sinus infection believed he was being treated at an urgent care clinic, only to later receive an \$11,251 bill, including a \$6,237 facility-usage fee, after he walked into an FSED instead.⁹ In the aggregate, the stakes are even higher: matching the condition with the appropriate care setting could save Coloradans \$800 million per year, with an average savings per individual of \$1,150 per visit.¹⁰

Transparency in the ED provides for the education of individuals by allowing them to weigh their treatment options and costs. But many Colorado EDs decline to discuss pricing until after screening and treatment.¹¹ Thus, a patient presenting to the ED may blindly walk into screening and treatment with no knowledge of the costs that she may incur.

Concerned about the lack of disclosure around the higher costs of EDs, two Colorado legislators introduced State House Bill 16-1374 in 2016.¹² HB 16-1374 had two principal

9. *Centennial Man Billed \$11,251 To Get Sinus Infection Checked Out*, FOX31 DENVER (Apr. 15, 2016, 9:09 PM), <http://kdvr.com/2016/04/15/centennial-man-billed-11251-to-get-sinus-infection-checked-out/> [<https://perma.cc/DX6W-2BFQ>].

10. CTR. FOR IMPROVING VALUE IN HEALTH CARE, COST DRIVER SPOT ANALYSIS: AVOIDABLE EMERGENCY DEPARTMENT USE 1 (2015) [hereinafter CIVHC ED USE] (assuming individuals head to an urgent care or primary care physician as opposed to an ED).

11. *See, e.g.*, FOX31 DENVER, *supra* note 9; *see also* Chris Vanderveen, *BuyER Beware: Federal Law Keeping Patients in the Dark*, 9NEWS (May 11, 2016, 9:00 PM), <http://www.9news.com/news/investigations/buyer-beware/buyer-beware-federal-law-keeping-patients-in-the-dark/185504166> [<https://perma.cc/QC6G-DG87>].

12. H.B. 16-1374, 70th Gen. Assemb., 2nd Reg. Sess. (Colo. 2016), http://leg.colorado.gov/sites/default/files/documents/2016a/bills/2016A_1374_01.pdf [<https://perma.cc/ESY5-9DDL>]. Then-Representative Beth McCann and Senator John Kefalas introduced the bill on March 16; on May 4 it passed the House 34-31; on May 5, the Senate Committee on State, Veterans, and Military Affairs postponed it indefinitely. *Bill History*, COLO. GEN. ASSEMBLY, <http://leg.colorado.gov/bills/hb16-1374> (last visited Mar. 11, 2017) [<https://perma.cc/6K8C-TZ3D>]. States other than Colorado have also introduced legislation to solve these problems, but they have been more drastic. *See* Carol M. Ostrom, *Gregoire Suspends Plan To Limit Medicaid Emergency-Room Visits*, SEATTLE TIMES (Mar. 31, 2012, 6:20 PM), <http://www.seattletimes.com/seattle-news/gregoire-suspends-plan-to-limit-medicaid-emergency-room-visits/> [<https://perma.cc/WK5G-ZDQX>]. Washington's Medicaid program was going to stop paying for ED visits for those on Medicaid found to have non-emergency conditions. *Id.* Washington's predicted cost savings to the state Medicaid program would be at least \$21 million a year. *Id.* However, it was suspended by the Governor. *Id.*

requirements. First, the bill required FSEDs to post signage stating that the facility is an emergency medical facility that treats emergency conditions.¹³ Second, the bill required FSEDs to make certain disclosures relating to continuing treatment costs after screening the patient for emergency conditions.¹⁴ However, the Colorado Hospital Association (CHA) asserted that the signage and disclosure requirements discouraged patients from seeking care and thus violated the federal Emergency Medical Treatment and Labor Act (EMTALA).¹⁵ Congress enacted EMTALA in 1986 to crack down on emergency departments that were refusing to treat poor patients.¹⁶ The Act prohibited EDs from screening patients based on their ability to pay, but has since been expanded to generally prohibit EDs from delaying or discouraging patients from seeking treatment.

An FSED's disclosure obligations under HB 16-1374 primarily commence after staff screen the patient for an emergency medical condition.¹⁷ At this stage, patients have already accrued the facility fee and costs for screening. HB 16-1374 is unlikely to reduce costs or increase transparency because the disclosures come too late. This Comment proposes the Pre-Screen Notice, a stronger alternative to HB 16-1374. The ED presents the patient with the Pre-Screen Notice before screening and treatment, and it is carefully tailored to reassure and empower her to actively participate in her care. The Notice also applies to all EDs; it is not limited to FSEDs like HB 16-1374.

Part I outlines an ED's EMTALA obligations. Part II introduces HB 16-1374 and this Comment's proposed alternative, the Pre-Screen Notice, and concludes that neither

13. H.B. 16-1374.

14. *Id.*

15. FOX31 DENVER, *supra* note 9; Examination and Treatment for Emergency Medical Conditions and Women in Labor, 42 U.S.C. § 1395dd (2012) (popularly known as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the Patient Anti-Dumping Statute).

16. *See infra* Section I.A. Scholarship on EMTALA since its enactment in 1986 has focused on a range of diverse issues. *See, e.g.*, E.H. Morreim, *EMTALA: Medicare's Unconstitutional Condition on Hospitals*, 43 HASTINGS CONST. L.Q. 61 (2015) (discussing the constitutionality of EMTALA); *see, e.g.*, Tristan Dollinger, Note, *America's Unraveling Safety Net: EMTALA's Effect on Emergency Departments, Problems and Solutions*, 98 MARQ. L. REV. 1759 (2015) (discussing screenings, stabilizing treatment, discharge, and transfer).

17. H.B. 16-1374.

violate EMTALA. Part III compares the two solutions' benefits and drawbacks for both the patient and the ED. This Comment argues that the Pre-Screen Notice is needed to encourage thoughtful, quality care while reducing consumer costs and increasing transparency.

I. HISTORY AND PURPOSE OF EMTALA

As discussed in this Part, EMTALA's purpose is apparent based on the bill's language, legislative history, and historical context: Congress designed EMTALA to guarantee life-saving treatment to all individuals with emergency medical conditions regardless of their ability to pay. Under EMTALA, it is illegal for EDs to turn patients away without first screening them for emergency conditions.¹⁸ Subsequent regulations implementing EMTALA have widened its scope and bolstered enforcement.¹⁹ Currently, the safest route for EDs is to remain silent when new arrivals inquire about treatment options and costs, for fear that any answer will later be interpreted as snubbing patients.²⁰ This Part analyzes those regulations and provides the formula for Part II's conclusion that EMTALA does not stifle information exchange—neither HB 16-1374 nor the Pre-Screen Notice run afoul of EMTALA. However, to overcome EDs' resistance to change and to empower patients, the pre-screen notice is required.

A. *A Response to Patient Dumping*

As true today as it was when EMTALA was enacted three decades ago, EDs are the primary providers of treatment and care for the uninsured.²¹ The 1980s saw a significant increase in the number of uninsured patients, an increase which was

18. See 42 U.S.C. § 1395dd.

19. See *infra* Sections I.B, I.C.

20. In a letter from Paul M. Bunge to the Honorable Peter W. Rodino, Jr., Bunge warned that enforcement of EMTALA "can only be obtained through the retrospective evaluation of intimate medical diagnostic and treatment decisions which have heretofore been left exclusively to the judgment of the physician and his patient. If [EMTALA] becomes law, however, those decisions will be subject to the second opinion of federal prosecutors." H.R. REP. NO. 99-241, pt. 3, at 16 (1985).

21. Karen Treiger, Note, *Preventing Patient Dumping: Sharpening COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1187 (1986).

exacerbated by reduced government reimbursement rates to health care providers for Medicaid recipients.²² This forced the uninsured to use EDs for care, and as uncompensated care costs mounted, hospitals closed their doors to the uninsured through the act of “patient dumping.”²³ Patient dumping is the “transfer of patients from one hospital to another primarily for economic reasons,”²⁴ but more broadly it covers the rejection of patients based on their socioeconomic status, race, ethnicity, or appearance.²⁵

While patient dumping may manifest itself subtly, as when a clinical attendant ignores a patient for hours until they leave, often it is more blatant.²⁶ For example, a hospital administrator lifted Terry Takewell, a young man suffering from an emergency medical condition, out of the hospital's bed, carried him to the parking lot and left him outside without his shirt or shoes.²⁷ Terry was uninsured and owed the hospital for previous treatment.²⁸ He died the next day.²⁹ Heartbreaking stories like Terry's filled *The New York Times* and *The Washington Post*,³⁰ provoking Congress to enact

22. H.R. REP. NO. 100-531 at 7 (1988).

23. *Id.* at 4 (citing a number of studies conducted between 1984 and 1986 which found that the victims of dumping were most often the uninsured, followed by those on Medicaid and Medicare); see also Paul Taylor, *Ailing, Uninsured and Turned Away*, WASH. POST (June 30, 1985), https://www.washingtonpost.com/archive/politics/1985/06/30/ailing-uninsured-and-turned-away/8d83c59d-15fa-4527-94a7-ef47b6779e50/?utm_term=.f7635d6ddf37 [<https://perma.cc/J3EW-ZTGD>].

24. H.R. REP. NO. 100-531 at 1.

25. *Id.* at 3.

26. *Equal Access to Health Care: Patient Dumping Before the H. Subcomm. on Human Res. and Intergovernmental Relations of the Comm. On Gov't Operations*, 100th Cong. 2 (1987) (statement of Rep. Ted Weiss, Chairman, subcommittee on Human Res. and Intergovernmental Relations) (“[Patient dumping] can be carried out by transferring a patient to another hospital, refusing to treat them, or subjecting them to long delays before the patient finally leaves.”).

27. H.R. REP. NO. 100-531 at 11.

28. *Id.*

29. *Id.*

30. Treiger, *supra* note 21 at 1188 n.16 (citing Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES (May 25, 1986), <http://www.nytimes.com/1986/05/25/weekinreview/treating-an-outbreak-of-patient-dumping-in-texas.html> [<https://perma.cc/46J7-RHDP>]); Taylor, *supra* note 23; Editorial, *Health and Hot Potatoes*, WASH. POST (Mar. 16, 1985), https://www.washingtonpost.com/archive/politics/1985/03/16/health-and-hot-potatoes/3a8926e3-0ccf-4a24-aeaa-97bca2501648/?utm_term=.27c76d842eff [<https://perma.cc/DZK8-TGFW>]; Editorial, *Emergencies Need Open Hospitals*, N.Y. TIMES (May 15, 1982) <http://www.nytimes.com/1982/05/15/opinion/emergencies-need-open->

EMTALA.³¹

The purpose of EMTALA, said Senator Durenberger when introducing its framework to Congress, “is to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”³² EMTALA only ensures “an adequate first response to a medical crisis,”³³ it does not contemplate continuing care, follow-up visits, or services beyond screening and stabilization of an emergency condition. In short, Senator Durenberger did not write EMTALA for today’s reality of ubiquitous free-standing EDs,³⁴ booked primary care physicians,³⁵ or individuals seeking treatment at EDs for non-emergency conditions such as twisted ankles or minor cuts.³⁶ The Centers for Medicare and Medicaid Services (CMS) stresses compliance with EMTALA while simultaneously acknowledging that individuals should be treated at the appropriate care site.³⁷ These are not mutually exclusive, but EDs skew towards an overly restrictive interpretation of EMTALA. Violations by EDs carry strict penalties, including fines and expulsion from Medicare.³⁸

hospitals.html [https://perma.cc/53B6-H5AR].

31. EMTALA was enacted through an amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in April 1986, and thus is sometimes also referred to as the COBRA anti-dumping law. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, sec. 9121, § 1867, 100 Stat. 151, 164–167 (1986) (codified at 42 U.S.C. § 1395dd). For the regulations implementing EMTALA, promulgated by the Centers for Medicare and Medicaid Services (CMS), of the Department of Health and Human Services (HHS), see 42 C.F.R. § 489.24 (2016).

32. 131 CONG. REC. 28,568 (1985).

33. *Id.* (statement of Sen. Dole).

34. Olinger, *supra* note 6.

35. It takes, on average, 29 days to set up an appointment with a family care physician, compared to 19.5 days in 2014. Nelson D. Schwartz, *The Doctor Is In. Co-Pay? \$40,000*, N.Y. TIMES (June 3, 2017), https://www.nytimes.com/2017/06/03/business/economy/high-end-medical-care.html?_r=0 [https://perma.cc/Q2QH-YAG2] (citing MERRITT HAWKINS, 2017 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES AND MEDICARE AND MEDICAID ACCEPTANCE RATES (2017)).

36. COLO. HEALTH INST., *supra* note 2. For other non-life threatening medical conditions, and guidance as to where to seek treatment, see *When to Use the Emergency Room – Adult*, MEDLINEPLUS, <https://medlineplus.gov/ency/patientinstructions/000593.htm> [https://perma.cc/C4AR-8XBF].

37. CMS, 68 Fed. Reg. 53,222, 53,224 (Sept. 9, 2003) (“Reports of overcrowding are common in many parts of the country.”).

38. See *infra* Section I.C.

B. *An ED's EMTALA Obligations*

Since EMTALA's enactment, CMS has supplemented EMTALA with regulations and interpretive guidance, widening its scope.³⁹ This Section details an ED's obligations under EMTALA by following an individual's journey through the ED.

1. Arrival at the ED

In the early afternoon, Jane Doe entered the main door of Banner Fort Collins Medical Center in Fort Collins, Colorado.⁴⁰ She cut her hand on a door the previous night.⁴¹ Though she had applied a large amount of Super Glue over the two-centimeter cut before seeking help, the wound was still bleeding.⁴²

EMTALA states an ED's obligations begin when a patient requests treatment: a medical screening exam is required "if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition."⁴³ Yet, CMS has construed EMTALA to require the registration of all patients presenting, regardless of request.⁴⁴ Under the agency's regulations, EMTALA obligations begin when the individual enters onto either hospital property or a hospital's ED, at which point a request may be implied.⁴⁵ An ED's EMTALA obligations begin as soon as a patient enters hospital property if a "prudent

39. *See, e.g.*, CTRS. FOR MEDICARE AND MEDICAID SERVS., 100-07 STATE OPERATIONS MANUAL app. V (2010), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf [<https://perma.cc/S6RV-VHQT>].

40. *Full Text Statements of Deficiencies Hospital Surveys, Related Links, Hospitals*, CTRS. FOR MEDICARE AND MEDICAID SERVS., EVENT_ID VH0K11, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html> (last visited June 5, 2017) [<https://perma.cc/2VTM-9P4K>] [hereinafter *Hospital Surveys*]. In this action (the report omits the patient's real name), Office of Inspector General (OIG) inspectors found that staff discussed discounted treatment options with a patient before registering that patient in the ED, and thus before a medical screening examination. *Id.* OIG stated the ED in this instance violated EMTALA because it delayed treatment and discouraged the individual from receiving care. *Id.*

41. *Id.*

42. *Id.*

43. 42 U.S.C. § 1395dd(a) (2012).

44. *See* 42 C.F.R. § 489.24 (2016).

45. 42 C.F.R. § 489.24.

layperson,” observing that patient’s behavior and appearance, would believe that the patient has an emergency medical condition.⁴⁶ For patients who arrive at the ED and not through another door at the hospital, the threshold is even lower: EMTALA requires that ED staff register and screen any patient who arrives at the ED and appears to have a medical condition.⁴⁷

2. Patient Registration

If staff thought Jane Doe had an emergency medical condition, then per EMTALA, they would have immediately ushered Doe to the ED to register and receive a screening examination, which is designed to uncover potential emergency medical conditions.⁴⁸ Once in registration, ED staff would delay proactively discussing any registration forms that would require Doe to disclose her insurance status or ability to pay until ED staff screened and stabilized her.⁴⁹ The ED may collect general registration information, like Doe’s demographics and emergency contact; however, the inquiry must not discourage Doe from remaining to receive care, nor delay the screening.⁵⁰ EMTALA does not define what constitutes a “delay.”⁵¹

3. Inquiries Regarding Payment or Insurance Status

Upon entering the facility, Jane Doe expressed concern about the cost of an ED visit.⁵² Staff provided Doe with informational brochures, contacted a financial employee by phone for assistance, and worked with her to successfully obtain discounted health care *before* they registered her with the ED.⁵³ During this time she continued to bleed.⁵⁴ At 4:19

46. 42 C.F.R. § 489.24(b)(2).

47. § 489.24(b)(1).

48. 42 U.S.C. § 1395dd(a), (h).

49. OIG/HCFE Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. 61,353, 61,355 (Nov. 10, 1999) [hereinafter Special Advisory Bulletin]; *see* 42 U.S.C. § 1395dd(h).

50. Special Advisory Bulletin, 64 Fed. Reg. at 61,355.

51. *See* 42 U.S.C. § 1395dd.

52. *Hospital Surveys*, *supra* note 40.

53. *Id.*

54. *Id.*

p.m., “quite a while” after she entered the facility, Doe registered with the ED.⁵⁵ But did the ED discourage or delay screening or treatment in light of her unprompted concern about the cost?

The statute itself is silent on whether an ED can be penalized for a delay resulting from an inquiry like Doe's.⁵⁶ EMTALA only prohibits delay “to inquire about the individual's method of payment or insurance status.”⁵⁷ The ED is the subject, and the plain meaning of “inquire” suggests that the statute only explicitly prohibits delay resulting from EDs asking about payment and insurance. If left only with the text of the statute itself, an ED may wonder precisely what information it may provide to Doe. If Doe inquires as to her treatment options and costs, may an ED then ask about her price sensitivity and insurance?

Given EMTALA's silence, HHS has provided some guidance to EDs concerning patients, like Doe, who personally inquire about treatment options and costs.⁵⁸ While HHS has eschewed bright-line rules, its guidance allows for more candid discussions with curious patients than is currently common in the industry.⁵⁹

The agency explicitly denies that its guidance prevents EDs from providing patients with full disclosure.⁶⁰ Per the agency, were Doe to question her financial responsibility at the ED, only knowledgeable staff trained on EMTALA and

55. *Id.*

56. *See* 42 U.S.C. § 1395dd.

57. *Id.* § 1395dd(h) (emphasis added).

58. In 1998, HHS, specifically the Office of Inspector General (OIG) and the Health Care Financing Administration (HCFA), solicited comments on a proposed Special Advisory Bulletin. The Bulletin addressed EMTALA's application to individuals insured through managed care plans, which often required pre-approval for coverage, even in emergencies. Notice of Proposed Special Advisory Bulletin on the Patient Anti-Dumping Statute, 63 Fed. Reg. 67,486, 67,486–87 (proposed Dec. 7, 1998). Thus, in 1998, some EDs contacted patients' primary care physicians or plans before screening and treatment. *Id.* Otherwise, the patient was forced to pay the cost out-of-pocket, a risky proposition for the hospital. *Id.* OIG was concerned that these inquiries delayed screening, or otherwise discouraged patients from seeking treatment. *Id.* Of the over 150 comments to HHS, many concerned payment issues, particularly how EDs should handle patient inquiries and how EDs might notify patients of their payment responsibility. Special Advisory Bulletin, 64 Fed. Reg. 61,353, 61,354 (Nov. 10, 1999).

59. *See* Special Advisory Bulletin, 64 Fed. Reg. at 61,355–59.

60. *See id.*

financial liability should respond.⁶¹ Before any response, staff must reassure Doe that their facility is committed to providing her with a screening and necessary treatment to stabilize any emergency medical condition.⁶² Finally, staff should encourage Doe to defer discussions until after ED staff have screened and stabilized her.⁶³ Despite these caveats, trained staff should answer Doe's inquiries "as fully as possible."⁶⁴

4. Screening for an Emergency Medical Condition

The statute only provides that Doe's screening be "appropriate," within the capability of the ED and sufficient to identify an emergency medical condition.⁶⁵ Courts have struggled to define "appropriate" in the context of EMTALA, with one court calling it "one of the most wonderful weasel words in the dictionary."⁶⁶

The screening process to determine whether Jane Doe has an emergency medical condition can be tailored to her symptoms and medical history so long as the screening is applied uniformly to any other patient presenting in that manner.⁶⁷ Screenings do not need to be equally comprehensive.⁶⁸ They cannot, however, be influenced by the discounted cost Doe negotiated prior to screening.

An "emergency medical condition" is defined as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain . . .) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) [p]lacing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

61. *See id.*

62. *See id.* at 61,359.

63. *See id.* at 61,355–59.

64. *See id.* at 61,355.

65. 42 U.S.C. § 1395dd(a).

66. *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

67. *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992); *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 39, at 46 (interpreting 42 C.F.R. § 489.24(c)).

68. CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 39, at 46.

- (ii) [s]erious impairment to bodily functions, or
- (iii) [s]erious dysfunction of any bodily organ or part⁶⁹

The definition has a narrow temporal scope, pertaining only to present symptoms requiring immediate medical attention to avoid serious harm.

If it is clear Doe does not have an emergency medical condition, a hospital may have a registered nurse or similar practitioner conduct the screening exam, so long as it is within their scope of practice and within the ED's protocol.⁷⁰ If the ED were to determine that Doe has an emergency medical condition, the ED must stabilize her within the facility's resources.⁷¹

The ED may not transfer Doe to another hospital before administering stabilizing treatment unless Doe provides informed written consent, or a physician certifies in writing that the benefits of transferring her to another facility outweigh the possible risks from moving her.⁷² The transfer must also be medically beneficial and successful.⁷³

5. Withdrawing Requests for Screening or Treatment

EDs have no obligation to respond to Jane Doe's expressed concern about the cost of treatment at the ED. If met with silence, Doe could leave and seek treatment elsewhere. If the ED was aware of her intent to leave, the ED, under EMTALA, must reaffirm its commitment to screening and treatment, inform her of any risks of withdrawal, and take reasonable steps to obtain her written informed consent to refuse screening and treatment.⁷⁴ ED staff would need to detail any discussion between staff and Doe regarding her treatment options and costs and place her signed consent form in their records.⁷⁵ If she were to leave the ED without notice, staff would need to note the approximate time she entered and

69. 42 C.F.R. § 489.24(b).

70. CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 39, at 46.

71. 42 U.S.C. § 1395dd(b)(1)(A).

72. *See id.* § 1395dd(c)(1)(A) (1395dd(c)(1)(A) also includes a person legally acting on the individual's behalf, and a qualified medical professional acting in consultation with a physician).

73. *See id.* § 1395dd(c)(2).

74. *See* Special Advisory Bulletin, 64 Fed. Reg. 61,353, 61,359 (Nov. 10, 1999).

75. *Id.*

exited and any conversations with ED staff.⁷⁶

C. *Enforcing EMTALA*

Without legislation empowering patients and requiring transparency and disclosure when a patient inquires about costs and options, EDs will continue to choose silence as the easiest path to comply with EMTALA. For example, in an investigation, the ED carries the burden of proving it took appropriate steps to discourage a patient from leaving the hospital before screening.⁷⁷ A record of the patient's written consent and supporting paperwork are crucial, and a single oversight can lead to severe penalties for the ED.⁷⁸ Noncompliance can be crippling. EMTALA's requirements are incorporated into each hospital's Medicare provider agreement.⁷⁹ Failure to meet them constitutes a breach of the agreement and may lead to termination—meaning a ban on receiving Medicare and Medicaid payments.⁸⁰ Physicians and hospitals may also be subject to monetary penalties and civil action.⁸¹ These stiff penalties compel EDs into strict compliance and incentivize a broad, overly cautious reading of an ED's obligations. Opaque enforcement and ambiguous regulations make complying with EMTALA a challenge too, and exacerbate EDs' reticence to respond to patients about costs and treatment options.⁸²

Obtaining discounted care for a patient with a non-urgent medical condition is laudable. Staff at Banner Fort Collins Medical Center ensured Jane Doe received discounted

76. *Id.*

77. *Id.*

78. *Id.* Recently, CMS has penalized EDs for transferring patients who, according to the ED, asked to transfer for economic reasons. *Hospital Surveys*, *supra* note 40. In no case was the box, "at the patient's request," checked and signed by the patient on the transfer document. *Id.*

79. OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVICES, OEI-09-98-00221, THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 6 (2001).

80. *Id.*

81. *Id.* Between 2002 and 2015, there were 192 EMTALA-related settlements, with fines against physicians and hospitals totaling \$6,357,000. Nadia Zuabi et al., *Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements*, 18 WESTERN J. EMERGENCY MED. 245, 245 (2016). Of those settlements, seventy-five percent were for failing to screen for an emergency medical condition. *Id.*

82. *Id.*

treatment in response to Doe's direct inquiry upon entering the facility.⁸³ However, Doe's situation falls into a grey area: was her cut an emergency medical condition; was she reluctant to register with the ED; did staff reassure her she would be treated despite her inability to pay?

A medical screening examination is the bedrock of EMTALA. But *requiring* every patient to receive a screening examination is different than ensuring a screening is *available* to all. The statute only contemplates the latter—that screening is available upon request.⁸⁴ Subsequent regulations mandate the former by broadening the request to include those who appear with a simple injury or illness.⁸⁵ Since Doe appeared through the main door and not the ED,⁸⁶ the presence of an implied request would be subject to the higher standard: whether she appeared to have an emergency medical condition.⁸⁷ By entering through the main door and inquiring about discounted options for treatment, Doe delayed her request to be seen at the ED. A prudent layperson could have believed that she was not suffering from an emergency medical condition.⁸⁸ With neither an emergency medical condition nor a request for screening or treatment, EMTALA appears not to apply. The hospital could work through Doe's requests without incurring EMTALA violations.

In contrast, Office of Inspector General (OIG) inspectors found that EMTALA *did* apply to Doe's situation.⁸⁹ OIG stated the ED violated EMTALA because it delayed treatment and discouraged Doe from receiving care.⁹⁰ The only fact in the public report to suggest the hospital discouraged Doe was that staff was willing to respond to her request for information on discounted treatment options before registering and screening her in the ED.⁹¹

OIG and Health and Human Services (HHS) should tailor their enforcement of EMTALA to increase the availability of emergency care to patients with medical emergencies in

83. *Hospital Surveys*, *supra* note 40.

84. *See* 42 U.S.C. § 1395dd(a).

85. *See* 42 C.F.R. § 489.24 (2016).

86. *Hospital Surveys*, *supra* note 40.

87. § 489.24(b)(1).

88. *Id.* § 489.24(b).

89. *Hospital Surveys*, *supra* note 40.

90. *Id.*

91. *Id.*

accordance with EMTALA's purpose.⁹² Senators contemplating the bill in early stages recognized medical decisions do not occur in a vacuum with limitless funds. When introducing the bill, Senator Durenberger said EMTALA "does not prevent hospitals from making appropriate and safe transfers of patients for economic reasons."⁹³ Rather, EMTALA prohibits EDs from abandoning patients with emergency medical conditions.⁹⁴ By "appropriate and safe," Senator Durenberger likely meant that discussions with the patient should not interfere with her receiving life-saving treatment; ED staff should stabilize any patient they intend to transfer to another hospital for financial reasons. Although neither the Pre-Screen Notice nor HB 16-1374, to be presented in Part II, would immunize EDs from liability under EMTALA, they do comply with its obligations. If Colorado does not intervene, EDs will remain silent. The benefit to patients surpasses the EDs' additional costs, from training and hiring staff to answer patient inquiries to maintaining appropriate records.

II. THE LEGALITY OF THE TWO PROPOSED SOLUTIONS UNDER EMTALA

Part II introduces Colorado's HB 16-1374 and this Comment's alternative proposal, the Pre-Screen Notice. It addresses the legality of each proposal, in turn, under EMTALA.⁹⁵

A. *HB 16-1374*

In the spring of 2016, then-State Representative Beth McCann and State Senator John Kefalas introduced House Bill

92. See *supra* Section I.A; see also 131 CONG. REC. 28,568 (1985) (statement of Sen. Durenberger) ("The amendment is not a cure-all, it is a modest policy to address a problem which only recently began to emerge.")

93. 131 CONG. REC. 28,568 (statement of Sen. Durenberger); see *supra* text accompanying note 78 (discussing recent enforcement actions against transfers for economic reasons).

94. 131 CONG. REC. 28,568 (statement of Sen. Durenberger).

95. Only state or local laws that directly conflict with EMTALA's requirements are preempted. 42 U.S.C. § 1395dd(f). As argued in this Comment, neither HB 16-1374 nor the Pre-Screen Notice conflict with EMTALA's requirements, and thus neither are preempted.

16-1374 in the Colorado General Assembly.⁹⁶ The bill had two major requirements.⁹⁷ First, the bill would have required EDs to place signage reminding potential patients that they were in an FSED.⁹⁸ Second, upon diagnosis of a non-emergency medical condition, the bill would have required the facility to furnish a written statement.⁹⁹ This statement, to be signed by the patient, focused on the costs associated with further treatment at the facility, including warnings (i) that the patient's insurance may not cover it, (ii) that they would be charged rates and fees comparable to a hospital emergency room, and (iii) that they may want to consult their primary care provider.¹⁰⁰

Many health care providers opposed the bill, but their resistance was more likely over financial, rather than legal, concerns.¹⁰¹ The suggestion that the patient may wish to consult with her primary care doctor may cause some patients to pause before accepting treatment for non-emergency medical conditions or tests. Particularly, the post-screen disclosure could lead those individuals to seek cheaper treatment elsewhere.¹⁰²

Despite CHA's broad admonition about potential EMTALA violations, the bill's two provisions raise perfunctory legal concerns. First, the signage requirement arguably implicates the prohibition on discouraging or delaying patients from seeking treatment.¹⁰³ Second, the disclosure requirement after the diagnosis of a non-emergency medical condition potentially

96. H.B. 16-1374, 70th Gen. Assemb., 2nd Reg. Sess. (Colo. 2016).

97. *Id.*

98. *Id.* The signage requirement is possibly a response to individuals who think they are in an urgent-care facility, but are instead in a free-standing emergency department. *See, e.g.,* David Olinger, *Confusion About Free-Standing ER Brings Colorado Mom \$5,000 Bill*, DENVER POST (Oct. 30, 2015, 3:16 PM), <http://www.denverpost.com/2015/10/30/confusion-about-free-standing-er-brings-colorado-mom-5000-bill/> [<https://perma.cc/LXP8-EARC>] ("It would have been nice if they had said this is an emergency center.").

99. H.B. 16-1374.

100. *Id.*

101. *See infra* Sections II.A.1, II.A.2. Hospitals have more to gain from patients receiving treatment at EDs. Olinger, *supra* note 98 ("The federal government reimburses [emergency rooms] at much higher rates for services also provided by patients' doctors and urgent care clinics.").

102. Olinger, *supra* note 6 (quoting Janet Pogar, a Regional Vice President at Anthem Blue Cross Blue Shield, "[p]eople aren't opening up freestanding ERs because they lose money on them. They make a bucketload of money on those.").

103. 42 C.F.R. § 489.24(d)(4)(iv) (2016).

triggers regulations surrounding an appropriate medical screening examination.¹⁰⁴

1. The Signage Requirement: Treatment Requests and Delays

The signage requirement consisted of notices posted in conspicuous locations throughout the FSED that stated the facility is a “[f]reestanding emergency room that provides emergency services to patients with emergency medical conditions and is not an urgent care center or primary care provider.”¹⁰⁵ The content of the signage resembles CMS’s current signage requirement for any FSED that is owned and operated by a hospital.¹⁰⁶ These existing notices inform patients of their right to a medical screening exam and stabilizing treatment for emergency medical conditions.¹⁰⁷ HB 16-1374’s proposed signage explicitly identified the facility as an ED.¹⁰⁸ However, this alone is unlikely to discourage patients from seeking treatment. The proposed signage does not mention or reference the potential cost of treatment, insurance, or the facility fee.¹⁰⁹ Still, there is a possibility that HB 16-1374’s signage may increase the likelihood of EMTALA violations, despite the signage itself complying with EMTALA.

Assuming the patient mistakenly entered the ED instead of an urgent care, and understood EDs are more expensive, the patient is likely to leave upon viewing the sign. However, an ED’s EMTALA obligations may begin as soon as the patient steps foot in the ED through an implied request if that patient appears to have a medical condition.¹¹⁰ Thus, an ED may have a duty to pursue any patient leaving the ED, or at the very least, the ED may need to note a patient walked out.¹¹¹ For example, if the patient speaks to any staff member, even just to request directions to an urgent care facility, the ED may have

104. *See id.* § 489.24(c).

105. H.B. 16-1374.

106. § 489.20(q)(1), (2); *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 39, at 22.

107. *See* C.F.R. § 489.20(q); *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 39, at 22.

108. H.B. 16-1374.

109. *Id.*

110. *See* § 489.24(b)(1), (2).

111. *See* Special Advisory Bulletin, 64 Fed. Reg. 61,353, 61,359 (Nov. 10, 1999).

to log the conversation and encourage the individual to stay. This discourages EDs from working with a curious patient who is simply trying to gather information and from proactively assisting patients in matching their condition to the appropriate place of care.

2. The Post-Screen Disclosure Requirement

Contrary to the assertion made by the CHA,¹¹² HB 16-1374's written disclosure requirement is permissible under EMTALA. The bill explicitly stated that patient disclosures occur only after a medical screening examination establishes that the patient does not have an emergency medical condition.¹¹³ In this context, EMTALA obligations have ceased. The bill's sponsors chose to take the conservative approach; if given pre-screen, the individual disclosures would likely violate EMTALA, as they may discourage patients from receiving care.¹¹⁴

B. Pre-Screen Notice

HB 16-1374 satisfies EMTALA, but its conservative approach misses the prime opportunity that the Pre-Screen Notice provides: educating consumers before they accumulate any costs. While HB 16-1374's signage requirement may signal to some patients the potential for higher prices, it comes at a risk to EDs, which are burdened with EMTALA's recordkeeping requirements. The written Pre-Screen Notice provides HB 16-1374's signage disclosures plus key elements from its written post-screen notice, facilitating a discussion with trained personnel. The Colorado legislature should require EDs to give anyone seeking treatment the following notice immediately upon registration:

112. FOX31 DENVER, *supra* note 9.

113. H.B. 16-1374.

114. *Id.* In particular, disclosure of the specific facility fee amount and the warning of varying insurance coverage may discourage patients.

Statement of Patient's Rights¹¹⁵

We will screen and treat you regardless of your ability to pay.

You have a right to ask questions regarding your treatment options and costs.

You have a right to receive prompt and reasonable responses to questions and requests.

You have a right to reject treatment.

However, we encourage you to defer your questions until after we screen you for an emergency medical condition. This is an emergency medical facility that treats emergency medical conditions. This is not an urgent care center or primary care provider.

While HB 16-1374 skirts EMTALA by applying only after examination—patients still walk into the ED blind—the Pre-Screen Notice is tailored to comply with EMTALA, so it provides patients with information from the start. It neither delays screening or treatment¹¹⁶ nor unduly discourages an individual from seeking medical help.¹¹⁷

1. Delay in Screening or Treatment

The Pre-Screen Notice empowers patients to ask questions, meaning that any delay will be the patient's choice—a situation not considered by EMTALA.

The prohibition on registration processes that delay screening or treatment only contemplates inquiries initiated by the ED.¹¹⁸ For example, an ED may not ask the patient for

115. There is precedent for the notice in the Florida Patient's Bill of Rights and Responsibilities, which offers a comprehensive outline of what patients and providers can expect of one another. *See* Florida Patient's Bill of Rights and Responsibilities, FLA. STAT. § 381.026 (2016). Florida's includes sections on payment, information, and access to care. *See generally id.* Each provider, including those that offer emergency services and care, must make available at least a summary of the Bill to patients in writing. *Id.* at § 381.026(6). The summary is more comprehensive than this proposed notice and includes provisions relevant to all stages and types of treatment, including both inpatient and outpatient services. *Id.*

116. *See* 42 U.S.C. § 1395dd(h) (2012).

117. *See* 42 C.F.R. § 489.24(d)(4)(iv) (2016).

118. *See supra* Section I.B.3.

their method of payment or insurance status.¹¹⁹ Nor may EDs contact the patient's insurance company for pre-approval.¹²⁰ Although provided by the ED, the Pre-Screen Notice does not amount to an ED inquiry. The notice simply informs the patient that they may inquire, receive answers, and reject treatment if they wish. The requirement to notify patients will apply to all EDs, including FSEDs, thus negating any perception that this is a bypass of EMTALA designed by a handful of EDs.

CMS states that qualified health care professionals should respond to patient inquiries "as fully as possible."¹²¹ The final paragraph of the Pre-Screen Notice appropriately reaffirms the ED staff's commitment to deferring discussions about financial liability issues until after a screening exam and stabilization.¹²² The clear explanation of the screening's focus on identifying an emergency medical condition ensures the patient leads the conversation. If she knows she does not have an emergency medical condition, but rather a toothache or a sprained ankle, she can better understand what treatment entails at the ED.

2. Unduly Discourage

Unlike HB 16-1374's post-screen disclosure, the ED would provide this Pre-Screen Notice to every patient before her medical screening exam, when EMTALA still applies. The Pre-Screen Notice is carefully tailored to encourage the patient to remain for screening, while giving her control of care and costs within the bounds of EMTALA. This balance is attained by omitting a few potentially disruptive provisions found in HB 16-1374: that this facility charges ED rates plus a facility fee that your insurance may not cover, and that the physicians may bill you separately.¹²³ The Pre-Screen Notice expressly conveys to the patient that the ED's priorities are screening and stabilization, regardless of the patient's insurance or ability to pay.¹²⁴

119. § 1395dd(h).

120. § 489.24(d)(4)(ii).

121. Special Advisory Bulletin, 64 Fed. Reg. 61, 353, 61,355 (Nov. 10, 1999).

122. *Id.*

123. H.B. 16-1374, 70th Gen. Assemb., 2nd Reg. Sess. (Colo. 2016).

124. Special Advisory Bulletin, 64 Fed. Reg. at 61,356.

The Pre-Screen Notice reminds each patient that she has the right to reject an ED's services before she incurs any costs. It encourages EDs and patients to engage in a dialogue. An ED's discussion of the risks and benefits of screening and treatment may encourage the patient to stay. In that situation, the patient would likely leave more satisfied than if she incurred a thousand-dollar bill for screening and only afterwards read HB 16-1374's disclosures.

III. THE LIMITATIONS & BENEFITS OF HB 16-1374 & THE PRE-SCREEN NOTICE

Part III explores a Coloradan's journey through the ED if the Legislature were to enact either HB 16-1374 or the Pre-Screen Notice. It highlights the limitations and benefits of both proposals. The Pre-Screen Notice provides greater opportunity than HB 16-1374 for patients seeking better care and lower costs.¹²⁵ The Pre-Screen Notice encourages patients to ask questions as soon as they register with the ED; with more information, they can make better decisions. In contrast, HB 16-1374's signage requirement is merely a bandage, and its post-screen notice comes too late in the patient's care to influence decision-making.

A. *Registration and Choosing the Appropriate Site of Care*

In August 2015, Craig Hammer developed a headache and a small lump on the back of his head.¹²⁶ He chose an FSED in Westminster, Colorado, because the facility was near his home, and he thought that it would charge him comparable rates to

125. In 2008, researchers from the non-profit Institute for Healthcare Improvement posited that in order to improve the American health care system, the industry should pursue three aims: "improving the experience of care, improving the health of populations, and reducing per capita costs of health care." Donald M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFF. 759 (2008). Subsequently, these aims have been applied specifically to the emergency care setting and simplified to better care, better health, and lower costs. Shantanu Agrawal & Patrick H. Conway, *Aligning Emergency Care with the Triple Aim: Opportunities and Future Directions After Healthcare Reform*, 2 HEALTHCARE 184, 185 (2014).

126. Vanderveen, *supra* note 11.

an urgent care facility.¹²⁷ HB 16-1374's signage and the Pre-Screen Notice would have been among the first things Hammer encountered upon entering the ED. Both would have notified Hammer that he was not in an urgent care facility, but rather an emergency medical facility that treats emergency medical conditions. Both assume that patients know that FSEDs and EDs charge more than urgent care centers. But even if patients do not understand the pricing difference, the sign and notice at least prompt the patient to consider their urgent care and primary care options.

Ensuring the patient chooses the appropriate health care site benefits the patient, the ED, and the health insurance provider. While EDs may need to train more staff to deal with patient inquiries, the solutions should eventually decrease the number of individuals with non-emergency medical conditions seeking treatment in the ED. One mark of a better health care system is an emptier hospital—healthier populations seek treatment less frequently.¹²⁸ The same can be said of EDs, where many individuals with non-emergency medical conditions are seeking expensive, short-term treatment.¹²⁹ Seeking care from a primary care physician may lead to an overall decrease in chronic medical conditions as individuals seek longer-term preventative care.¹³⁰ Although a patient with a non-emergency condition will likely receive the same quality of care for immediate illness and injury regardless of setting,¹³¹ patients with emergency medical conditions may be able to receive more attentive screening and treatment if patients with non-emergency conditions avoided EDs.¹³² EDs would need to train staff in the voluntary withdrawal procedures and how to respond appropriately to patient inquiries,¹³³ but ultimately this should lead to more educated patients. For future treatment needs, these patients can draw upon their past experience to choose the appropriate site of care.

The written Pre-Screen Notice is superior to HB 16-1374's posted signage requirement. The notice, provided to a patient

127. *Id.*

128. Berwick et al., *supra* note 125, at 768.

129. Agrawal & Conway, *supra* note 125, at 185–86.

130. *Id.*

131. Weaver, *supra* note 4.

132. Robert W. Derlet, *Triage of Patients Out of the Emergency Department: Three-Year Experience*, 10 AM. J. EMERGENCY MED. 195, 195 (1992).

133. See Special Advisory Bulletin, 64 Fed. Reg. 61,353, 61,359 (Nov. 10, 1999).

like Hammer by ED staff, is more personal and informative than a prospective patient independently reading a sign. ED staff would also have had an opportunity to encourage him to stay. While many patients do not closely read every piece of paper at a medical facility, a notice encourages discussion, whereas the sign may simply cause a patient to walk out without considering her options. Because of EMTALA's broad classification of patients needing treatment,¹³⁴ patients who are seen leaving may nevertheless need to be registered, informed of the benefits and drawbacks of leaving, and asked to sign a form noticing they left voluntarily.¹³⁵

The Pre-Screen Notice avoids this scenario. It is designed to be unobtrusive; EDs would provide the notice in written form while registering the patient, but would not require the individual's signature in the interest of keeping the burden low. A written notice is also likely to be faster than the staff relaying the information verbally, and reduces the possibility that staff will forget or mischaracterize information. The Pre-Screen Notice offers just enough information to the patient, and flexibility for the provider, to only minimally disrupt the normal flow of patients through the ED. Regardless, it is an important step in educating patients and ensuring that they know their rights before submitting to any screening or treatment. Many patients may only skim the notice, but it nonetheless encourages greater transparency within the ED.

B. The Implementation of the Pre-Screen Notice During the Medical Screening Examination

Following registration, the ED screened Hammer to rule out an emergency medical condition.¹³⁶ Each state has its own body of medical malpractice laws and EDs have strong incentives to properly identify an emergency medical condition. For Hammer's headache, the ED claimed the protocol was to obtain a CT scan to rule out any underlying life-threatening conditions.¹³⁷ Thus, costly tests, including Hammer's CT scans, are likely to be included in the screening. According to Hammer, the doctor suggested two "precautionary" CT scans—

134. See *supra* Section I.B.1.

135. See Special Advisory Bulletin, 64 Fed. Reg. at 61,359.

136. See Vanderveen, *supra* note 11; see 42 U.S.C. § 1395dd(a) (2012).

137. Vanderveen, *supra* note 11.

one for his head and one for his neck.¹³⁸ When asked what they would cost, the ED refused to disclose the price, citing EMTALA.¹³⁹ After insurance, Hammer's total bill was \$10,000, compared to the \$320 that he would have paid had he scheduled an appointment at another facility and paid cash up front.¹⁴⁰

Had HB 16-1374 been enacted at the time, its signage requirement informing Hammer that he was in an ED, not an urgent care, would have been his only hope. Given the fact that CT scans are part of the standard screening protocol for head injuries,¹⁴¹ he would have already incurred the CT scan cost, plus the facility fee, before receiving its in-depth notice.

In contrast, had the Pre-Screen Notice been in effect, Hammer would have been more empowered to ask questions and press for informed answers after the doctor refused to tell him the cost of the precautionary CT scans. He also may have thought to simply walk out, after receiving the required discussion regarding benefits and disadvantages to seeking treatment elsewhere.¹⁴² By waiting to have the CT scans at an urgent or primary care facility, Hammer could have saved a significant amount of money.¹⁴³

It is unclear whether Hammer thought his injury was an emergency or life-threatening, but as one 35-year emergency medicine practitioner stated, “[y]ou can’t teach patients economics lessons when they don’t feel well.”¹⁴⁴ Of course, neither HB 16-1374 nor the Pre-Screen Notice are designed to elicit or compel the full disclosure of all options and their price, particularly when patients are in pain. After all, most patients using the ED do have emergency medical conditions.¹⁴⁵ But the Pre-Screen Notice does encourage patients and physicians to

138. *Id.*

139. *Id.*

140. *Id.*

141. Michael Koppenheffer, *New Evidence of Head CT Scan Overuse in the ED*, ADVISORY BOARD (Feb. 20, 2015, 10:00 AM), <https://www.advisory.com/research/physician-executive-council/prescription-for-change/2015/02/head-ct-scan-overuse> [<https://perma.cc/EEX5-7V53>].

142. See Special Advisory Bulletin, 64 Fed. Reg 61,353, 61,359 (Nov. 10, 1999).

143. Vanderveen, *supra* note 11.

144. Paul S. Auerbach, Opinion, *Why ER Visits for Non-Emergencies Aren't Going Away*, WALL ST. J. (Sept. 25, 2015, 6:06 PM), <http://www.wsj.com/articles/why-er-visits-for-non-emergencies-arent-going-away-1443218817> [<https://perma.cc/3TF3-34K6>].

145. COLO. HEALTH INST., *supra* note 2.

engage in a dialogue about care and costs. After reading the notice, patients may feel empowered to ask more questions about the risks and benefits of their screening and treatment. Thus, the Pre-Screen Notice does more to protect patients from an opaque process and surprise bills.

The Pre-Screen Notice may be redundant in the sense that many patients already know they can question medical staff, leave the facility, or receive a second opinion. The Notice, however, is as important for ED staff as it is for the patients. A health care system must work for the patient and recognize that “patients pull resources, rather than vice versa.”¹⁴⁶ As Hammer’s experience shows, ED staff may well continue to refuse to engage patients who ask about the cost and necessity of a medical procedure. Their silence may arise from a paternalistic, “doctor-knows-best” mentality or from fears of violating EMTALA. Without the Pre-Screen Notice acting as a statement of patients’ rights, ED staff will continue to dodge questions and patients will continue to accept the status quo. This perpetuates a “more-is-better” culture, in lieu of integrated care calibrated to the patient’s needs and wishes. One benchmark of exceptional health care is when patients can say of their physicians: “They remember me.”¹⁴⁷ While this benchmark is not specifically applicable to ED doctors, the Pre-Screen Notice facilitates this goal by encouraging patients and ED staff to cooperatively decide treatment options and costs, including whether a different care site would be more appropriate without running afoul of EMTALA.

C. Continuing Treatment: HB 16-1374’s Post-Screen Notice

While the Pre-Screen Notice is designed to foster a dialogue between practitioner and patient throughout the course of screening and treatment, inducing long-term cost-savings, HB 16-1374 is written more as a warning of higher costs. HB 16-1374 is designed to be much more confrontational, and it trades timeliness for comprehensiveness. Its notice consists of a written statement the patient must sign and

146. Berwick et al., *supra* note 125, at 768.

147. *Id.*

thoroughly discuss with ED staff after screening.¹⁴⁸ The statement includes a number of disclosures that are much more likely to encourage an individual to seek treatment elsewhere. These include a warning that FSEDs charge a facility fee plus rates comparable to a hospital ED. It further provides that for non-emergency conditions the patient may wish to confer with their primary care physician before seeking further treatment. Since this comes after the screening examination, EMTALA does not apply, so the direct notices here are fine. However, the disclosures likely come too late for cost-sensitive patients; a patient will have already incurred bills from screening.¹⁴⁹ In Hammer's case, this would have likely included his CT scans.

D. But Can the Pre-Screen Notice Pass the Legislature?

The Pre-Screen Notice is not HB 16-1374's replacement. HB 16-1374 warns patients that EDs are pricier than alternatives; the Pre-Screen Notice prompts consumers to participate in their health care, while ensuring providers are more transparent.

Price transparency and health care industry accountability are not partisan issues. Everyone has been or will be a patient in the health care system. By taking an active role in their treatment and reviewing their options, patients can decrease their overall medical costs by 5.3 percent and decrease their hospital admissions by 12.5 percent.¹⁵⁰ The medical cost

148. H.B. 16-1374, 70th Gen. Assemb., 2nd Reg. Sess. (Colo. 2016).

149. At least some health care providers claim to work with patients when possible in a procedure closely resembling the requirements set forth in HB 16-1374. For example, according to *The Denver Post*, First Choice screens every patient for an emergency medical condition, after which those with non-emergency conditions are referred to their family doctor, if they have one. Michael Booth, *Colorado For-Profit ERs Next to Starbucks: Convenience and Controversy*, DENVER POST (July 29, 2013, 2:45 PM), <http://www.denverpost.com/2013/07/29/colorado-for-profit-ers-next-to-starbucks-convenience-and-controversy-2/> [<https://perma.cc/F65J-ZC9U>]. *But see* Auerbach, *supra* note 144 ("Emergency physicians are obligated by law to perform a screening exam, which is usually sufficient to achieve a working diagnosis. At that point, it defies the Hippocratic oath to send a patient elsewhere.").

150. *See, e.g.*, Laura Landro, *How to Get Patients to Take More Control of Their Medical Decisions*, WALL ST. J. (Feb. 28, 2017), <https://www.wsj.com/articles/how-to-get-patients-to-take-more-control-of-their-medical-decisions-1488164941> [<https://perma.cc/HGF4-GKNH>] (citing a 2013 study in which patients who were encouraged to review options and get more involved in choices had 5.3 percent lower overall medical costs and 12.5 percent fewer hospital admissions).

savings are even greater when patients forego the ED in favor of an urgent care or primary care visit for a non-emergency medical condition.¹⁵¹ The Pre-Screen Notice provides the patient with the mindset and confidence to ask questions and get answers. In turn, patients pay less while becoming healthier and more informed. Knowledgeable patients decrease their insurers' costs too; many companies offer resources for patients to pick the appropriate site of care.¹⁵²

The Pre-Screen Notice, in the form of the Statement of Patient's Rights, is the logical next step. Its provisions are not radical, but progress the health care industry towards parity with other consumer services. For the past two years, the Colorado Health Institute (CHI) highlighted legislative trends in transparency surrounding consumer health care costs.¹⁵³ The most recent report optimistically indicated that new chamber leaders and freshmen legislators are eager to engage in bipartisan legislation.¹⁵⁴ Two Democrats introduced HB 16-1374, but the bill was later postponed indefinitely by Republican Senators on the Committee on State, Veterans, & Military Affairs.¹⁵⁵ Subsequent bills introduced in the spring of 2017 by Republican Members of the U.S. Congress, however, suggest Colorado Republicans who back a cost-transparency proposal like the Pre-Screen Notice would be consistent with their party's platform.¹⁵⁶ The Republican-supported federal bills amend EMTALA to address the high costs consumers may face when seeking treatment in EDs.¹⁵⁷ The bills also focus on

151. CIVHC FSEDS, *supra* note 5.

152. *Urgent Care or ER? The Right Answer May Surprise You*, AETNA, <https://news.aetna.com/2015/12/urgent-care-or-er-the-right-answer-may-surprise-you/> (last visited July 1, 2017) [<https://perma.cc/3W3G-7739>] ; ITRIAGE, <https://www.itriagehealth.com/> (last visited July 1, 2017) [<https://perma.cc/CJL6-AFJY>].

153. COLO. HEALTH INST., 2016 LEGISLATION IN REVIEW (2016); COLO. HEALTH INST., 2017 LEGISLATION IN REVIEW (2017) [hereinafter 2017 LEGISLATION IN REVIEW].

154. 2017 LEGISLATION IN REVIEW, *supra* note 153, at 7 (2017).

155. The three Republicans on the Committee voted to postpone the bill indefinitely, over the objections of the two Democrats. *Final*, COLO. GEN. LEGISLATURE, <http://leg.colorado.gov/content/ssa2016a2016-05-05t100900z-hb16-1374-1-activity-vote-summary> (last visited Mar. 18, 2017) [<https://perma.cc/377V-LE46>].

156. *See* World's Greatest Healthcare Plan of 2017, H.R. 1275, 115th Cong. (2017); *see also* Medicaid Accountability and Care Act of 2017, S. 520, 115th Cong. (2017).

157. H.R. 1275; S. 520.

“price transparency,” including requiring providers—though excluding EDs—to disclose their prices in a form that makes it easy for consumers to compare similar services and items.¹⁵⁸ The bills do not directly impact the Pre-Screen Notice’s substance, but comport with the concept of providing consumers with more information about treatment options and costs.

Colorado is uniquely positioned to lead the nation in health care transparency and accountability. Throughout the past year, both Denver 9News and *The Denver Post* covered Coloradans’ experiences with EDs, from surprise bills to confusion spurred by the rise of FSEDs.¹⁵⁹ Increasing ED use and corresponding FSED construction is particularly acute in Colorado because of the rapid population growth and fewer regulatory hurdles than other states; Colorado does not require companies to prove community need for a medical facility before building.¹⁶⁰ Colorado is also supported by The Center for Improving Value in Healthcare (CIVHC). CIVHC administers the Colorado All Payer Claims Database, and educates Coloradans on their health care choices.¹⁶¹ The organization serves as a central hub for payment data, and has already made strides in transparency and accountability by releasing analyses on ED use.¹⁶² The Pre-Screen Notice would strengthen these efforts. Otherwise, patients will continue to spend more for short-term care at the

158. See S. 191, 115th Cong. (2017); see S. 520, 115th Cong. (2017); see H.R. 1275, 115th Cong. (2017).

159. See Olinger, *supra* note 6; see Booth, *supra* note 149; see FOX31 DENVER, *supra* note 9; see Vanderveen, *supra* note 11; see Olinger, *supra* note 98. For national coverage, see, Jane E. Brody, *Strategies to Navigate the Emergency Room*, N.Y. TIMES (May 15, 2017), <https://www.nytimes.com/2017/05/15/well/live/strategies-to-navigate-the-emergency-room.html?mabReward=CTM1&recp=0&module=Detail=recommendations-0&action=click&contentCollection=Television®ion=Footer&module=WhatsNext&version=WhatsNext&contentID=WhatsNext&src=recg&pgtype=article&r=0> [https://perma.cc/S6D9-MLDM]; see Landro, *supra* note 150; see *Can Consumers Be Smart Health-Care Shoppers*, Journal Reports: Health Care, WALL ST. J. (Apr. 11, 2017), <https://www.wsj.com/articles/can-consumers-be-smart-health-care-shoppers-1491962640> [https://perma.cc/9F6P-6PC9].

160. Weaver, *supra* note 4. Senate Bill 64 failed to pass in 2017, but it would have required FSEDs to obtain a license and to comply with new rules on safety and care standards, staffing, and transparency in billing. See 2017 LEGISLATION IN REVIEW, *supra* note 153, at 22.

161. See CTR. FOR IMPROVING VALUE IN HEALTH CARE, <http://www.civhc.org/> (last visited July 1, 2017) [https://perma.cc/3U5T-64U8].

162. CIVHC FSEDs, *supra* note 5; CIVHC ED USE, *supra* note 10.

ultimate expense of their long-term health.

CONCLUSION

Patients have the right to answers when they consider their health care options and costs. Currently, EDs are using EMTALA to obstruct a consumer's ability to make informed choices about their health care. EMTALA's provisions do not stifle information exchange. Former State Representative McCann and Senator Kefalas have already demonstrated in HB 16-1374 that the Colorado Legislature is looking out for Coloradans. But HB 16-1374 does not go far enough. This Comment's alternative proposal, with its requirement that patients' rights be handed to individuals in the form of a Pre-Screen Notice, is not only viable—it promises to be a more efficient and effective alternative.