PATIENT DUMPING: THE COBRA THAT NEVER STRUCK

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ABSTRACT

Hospitals throughout the United States, and specifically in California, sometimes refuse to treat unwanted patients and instead transfer them to other hospitals. This patient dumping primarily affects mentally ill and indigent individuals. This Note argues that although Congress and the state of California have taken steps to address the issue through legislation, and attorneys have brought forward innovative causes of action to seek reimbursement, further measures are needed to create lasting change. This Note suggests that Congress amend existing legislation, raise awareness about the persistence of patient dumping, and turn an eye towards the potential of the Affordable Care Act to assist in creating a durable solution.

TABLE OF CONTENTS

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I. INTRODUCTION

"I was fearful, I was scared, I was afraid."[1] These are the words of 42-year-old James Flavy Coy Brown, a homeless schizophrenic who was improperly discharged from state-run Rawson-Neal Psychiatric Hospital in Las Vegas, Nevada, on February 13, 2013.[2] With the assistance of Rawson-Neal employees, Brown was put on a one-way Greyhound bus to Sacramento, California.[3] He had only three days' worth of medication, and was told to "call 911, get an ambulance to the nearest hospital, and get [his] medication" upon arrival.[4] What Brown experienced is only one instance of a larger phenomenon that many other mentally ill and indigent individuals are familiar with—"patient dumping." Patient dumping, as used throughout the rest of this Note, encompasses two distinct phenomena: hospital refusals to admit and treat people despite emergency needs, and inappropriate transfers of patients to other hospitals.[5]

This Note will provide a history of patient dumping, show the problems it presents today, and address the need for lasting change. Section II discusses the history of the relationship between patient dumping and the judiciary, as well as state and federal attempts to combat

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[1] *Rawson-Neal Patient Dumping Victim Tells His Story*, KSNV, http://www.mynews3.com/content/news/story/Rawson-Neal-patient-dumping-victim-tells-his-story/qn7qmbC5uk-JFjrcFa3c4Q.cspx (last updated May 2, 2012) [hereinafter *Victim Story*].

[2] Cynthia Hubert, *Vegas Mental Hospital Goofed On Patients Discharge To Sacramento, Official Concedes*, SACRAMENTO BEE, March 15, 2013, http://www.sacbee.com/2013/03/15/5264646/vegas-mental-hospital-goofed-on.html.

[3] *Id.*

[4] *Victim Story*, *supra* note 1.

[5] *See* Karen I. Treiger, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1186–87 (1986) (defining patient dumping as "when a hospital that is capable of providing the needed medical care . . . sends a patient to another facility . . . or simply turns the patient away because the patient is unable to pay.").

patient dumping through legislation. Section III of this Note will focus on three potential solutions to the problem of patient dumping: Emergency Medical Treatment and Active Labor Act ("EMTALA") actions by individual victims; state based emergency health care; and medical malpractice suits and reimbursement actions, both by individuals who have been dumped, and by localities where patients are dumped. This Note will further argue that litigation alone may not be the best solution to patient dumping, but that innovative causes of action that seek reimbursement may have the potential to curb patient dumping practices. Section IV proposes three new tools, in addition to litigation, that can help ameliorate the problem of patient dumping: amending EMTALA, raising awareness about patient dumping, and a new emphasis on the Affordable Care Act. Section V concludes.

II. PATIENT DUMPING—A SYSTEM IN CRISIS

A. THE ISSUE

A 1986 Chicago-based study defined patient dumping as "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere."[6] The study examined patients who had been transferred from public medical facilities based on their insurance status.[7] When asked about the reasons for transferring patients, 87 percent of transferring hospitals cited a lack of insurance as the reason the patients were dumped.[8]

In 1997, Harvard Medical School conducted a study with 458 hospital patients who were transferred to the emergency department of Highland General Hospital in Oakland, California.[9] The study concluded that 33 of the patients transferred to the emergency department at that hospital were jeopardized by the transfer.[10] 63 percent of the transfer patients did not have insurance coverage.[11] The study was unable to

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[6] David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 J. AM. MED. ASS'N 1500, 1500 (1987).

[7] *Id.*

[8] Thomas A. Gionis, Carlos A. Camargo, Jr. & Anthony S. Zito, Jr., *The Intentional Tort of Patient Dumping: A New Cause of Action to Address the Shortcomings of The Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 193 (2002).

[9] Treiger, *supra* note 5, at 1191.

[10] *Id.*

[11] *Id.*

determine why there were so many transfers because the transferring hospitals almost never kept records on them.[12] The study concluded that "the absence of medical reasons for the transfers and the admission by transferring hospitals that some patients were transferred because they could not pay 'suggests that in some cases transfers were motivated by the financial interests of private hospitals and physicians.'"[13]

More recent figures provided by the Office of the Inspector General ("OIG") indicate that over two dozen patient dumping suits have been settled as of 2001.[14] This statistic represents only a fraction of the actual number of patient dumping instances across the country.[15] Recent investigations by the Los Angeles Times and the Sacramento Bee indicated that patient dumping continues to occur in some of California's biggest cities.[16] The investigations indicated that patient dumping is a countrywide issue, as many hospitals dump their patients into cities across state borders.[17] For example, the Los Angeles Times indicated that, as of July 2008, one Nevada hospital alone dumped over 1500 patients in other states around the country.[18]

These studies and reports indicate that patient dumping disproportionately affects those who are uninsured and indigent, and that it continues to occur despite legislation intended to prevent it.[19] Table One, below, provides an illustration of how patient dumping has grown throughout the latter part of the twentieth century.[20] As the number of facility transfers increased, the number of EMTALA violations also

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[12] *Id.*

[13] *Id.* (quoting Himelstein et. al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 496 (1984)).

[14] *Patient Dumping*, OFFICE OF INSPECTOR GEN., https://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (last updated Aug. 8, 2014).

[15] The OIG website includes information on cases that individuals have chosen to bring before the OIG. Logically, there may be individuals who have not chosen to bring their cases before the board.

[16] Lee Romney, *San Francisco Sues to Recoup Costs for Patient 'Dumped' by Nevada Hospital*, LOS ANGELES TIMES, Sept. 10, 2013, *available at* http://articles.latimes.com/2013/sep/10/local/la-me-ln-san-francisco-patient-dumping-suit-20130910.

[17] *Id.*

[18] *Id.*

[19] Gionis, Camargo, Jr. & Zito, Jr., *supra* note 8, at 182 n. 35; Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 961–62 (1992) ("[T]he current definition may not include mental patients who pose a danger to themselves and definitely does not require emergency treatment of those who may endanger others.").

[20] *See* Gionis, Camargo, Jr. & Zito, Jr., *supra* note 8, at 197 (featuring a table showing how patient dumping has become more frequent).

increased.[21] Between 1992 and 1998, the number of EMTALA violations more than doubled from 86 cases to 262.[22]

TABLE ONE[23]

Year	Facility Transfers	EMTALA Investigations	EMTALA Violations	Percentage of Transfers Resulting in EMTALA Violations
1992	1093	315	86	8 percent
1993	1438	340	76	5 percent
1994	1730	370	137	8 percent
1995	1751	457	163	9 percent
1996	1639	349	199	12 percent
1997	1700	448	230	13 percent
1998	1798	412	262	14 percent
1999	1798	n/a	322	18 percent

[21] *Id.*

[22] *Id.* at 198.

[23] *Id.*

Given the prevalence of patient dumping and its growth, understanding the evolution of patient dumping legislation, and the legal responses to it, is important if a lasting solution is ever to be reached.

B. THE PROBLEM WITH COMMON LAW

The roots of patient dumping legislation begin with common law principles. A number of courts have held that hospitals do not have an affirmative duty to treat patients.[24] For example, in *Birmingham Baptist Hospital v. Crews*, the Alabama Supreme Court found that the treating hospital did not have an affirmative duty to treat patients.[25] There, a two-year-old child arrived in an emergency room complaining of shortness of breath.[26] The treating physician provided the child with needed oxygen and diagnosed her with diphtheria, a contagious disease.[27] The physician then told the father that he would not treat the child, and to take her home.[28] The child died shortly after leaving the emergency room.[29] The Alabama Supreme Court ruled that the hospital had not undertaken any affirmative duty to treat the child, and that it had no obligation to care for her health and safety.[30] Specifically, the court stated, "Defendant is a private corporation, and not a public institution, and owes the public no duty to accept any patient not desired by it."[31]

Similarly, in 1901, the Indiana Supreme Court decided *Hurley v. Eddingfield* and ruled that a physician had the right to refuse treatment to a patient, even though he was the only physician available to treat the patient at that time.[32] In that case, a local physician presented himself as a general practitioner, and was also the decedent's family physician.[33] When the decedent became ill and called for the physician's assistance, the physician refused to render aid and did not provide any explanation as to his decision.[34] In fact, "[n]o other patients were requiring appellee's immediate service, and he could have gone to the relief of decedent if he had been willing to do

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[24] W. KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 373–75 (5th ed. 1984).
[25] Birmingham Baptist Hosp. v. Crews, 157 So. 224, 226 (Ala. 1934).
[26] *Id.* at 225.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.* at 225–26.
[31] *Id.* at 225.
[32] Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901).
[33] *Id.*
[34] *Id.*

so."[35] The court explained that the state does not require the physician to practice "at all or on other terms than [the physician] may choose to accept."[36] Accordingly, the physician did not have an affirmative duty to treat the patient.[37]

For the most part, the judiciary does not have a strong history of holding hospitals liable for failing to treat patients in need.[38] Rather, it continues to allow hospitals to partake in patient dumping, and has helped patient dumping evolve into what it is today.

C. FEDERAL INTERVENTION

In an attempt to ameliorate some of the patient dumping issues resulting from common law decisions, Congress passed the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act.[39] The act required all hospitals receiving federal funding for construction or improvements to take on a reasonable amount of free or reduced-cost care for indigent patients for no more than twenty years.[40] However, because "reasonable" was undefined and hospitals were only required to comply for twenty years, the Act was ineffective.[41] For example, in 1982, Parkland Hospital, a public hospital serving Dallas, sued multiple counties for failing to care for resident indigents when they were dumped there.[42] Moreover, from 1981 to 1985, the number of transfers in Washington D.C. increased from 169 to 930.[43] In Chicago, the number of transfers increased from 1295 to 5652 from 1980 to 1984.[44]

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[35] *Id.*
[36] *Id.*
[37] *Id.*

[38] *See* Hernandez v. Smith, 552 F.2d 142, 144 (5th Cir. 1977) ("[A] medical facility may narrow the scope of its medical undertaking if it informs the patient of the limitation."); Payton v. Weaver, 182 Cal. Rptr. 225, 230 (Cal. Ct. App. 1982) ("Whatever collective responsibility [to treat a patient] may exist, it is clearly not absolute, or independent of the patient's own responsibility [to seek treatment elsewhere]."); Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135, 138–40 (Del. 1961) (holding that a hospital did not have a duty to admit a patient, unless it had an emergency ward and the patient was in an "unmistakable emergency").

[39] 42 U.S.C. § 291 (2012).

[40] *Id.* § 291c(e).

[41] *See* Andrew Jay McClurg, *Your Money or Your Life: Interpreting The Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 198 n.107 (1987) (discussing how the Hill-Burton Act was not enforced or followed, and how it was not until the late 1970s that the government actually stated a dollar amount each hospital needed to apply).

[42] *Id.* at 178 n. 23.

[43] *Id.* at 178–79.

[44] *Id.*

Given these figures, Congress moved swiftly to enact EMTALA in 1986.[45]

EMTALA was enacted in response to a growing concern about "the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured."[46] EMTALA requires hospitals receiving Medicare and Medicaid funding to provide a medical screening exam to any individual who comes to the emergency department, and requires examination or treatment for a medical condition.[47] Moreover, if a hospital determines that an individual has an emergency medical condition, it must then stabilize the condition or provide for an appropriate transfer.[48] A hospital may transfer unstable patients only if "a physician . . . 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."[49]

The Health Care Financial Administration and the OIG are responsible for enforcing EMTALA.[50] A hospital physician may be fined up to $50,000 per violation of EMTALA,[51] and OIG also has discretion to issue smaller penalties depending on the situation and the financial state of the hospital.[52] An individual can obtain monetary relief for any personal harm suffered as a direct result of the hospital's violation of the act, and a medical facility that incurs any financial loss as a result of another hospital's violation of any EMTALA requirement can seek damages equal to the financial loss.[53] If found in violation of EMTALA, a hospital can lose its Medicare funding, which provides millions of dollars to hospitals throughout the country.[54] However, even though certain facilities such as Rawson-Neal Psychiatric Hospital have violated EMTALA in the past, the Center for Medicare and Medicaid Services ("CMS") have yet to revoke

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[45] *Id.* at 175.
[46] Eberhardt v. City of L.A., 62 F.3d 1253, 1255 (9th Cir. 1995) (citing H.R. REP. NO. 99-241, pt. 3, at 5 (1985)).
[47] 42 U.S.C. § 1395dd(a) (2012).
[48] *Id.* § 1395dd(b)(1).
[49] *Id.* § 1395dd(c)(A)(ii).
[50] OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., THE EMERGENCY MEDICAL AND TREATMENT AND LABOR ACT: SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS 9 (2001) [hereinafter SURVEY], *available at* https://oig.hhs.gov/oci/reports/oci-09-98-00220.pdf.
[51] 42 U.S.C. § 1395dd(d)(1)(B)(ii).
[52] SURVEY, *supra* note 50, at 9.
[53] 42 U.S.C. § 1395dd.
[54] 42 C.F.R. § 489.24(g) (2014); 42 C.F.R. § 1003.105 (2014).

any of the $3.2 million it provides to the institution each year.[55]

EMTALA was Congress's most recent attempt to curb incidents of patient dumping. However, it too has proved to be an inefficient tool in combatting patient dumping.[56] Key terms within the statute such as "emergency medical condition" and "appropriate medical examination" have been left undefined, and therefore subject to various interpretations.[57] This ambiguity has led to inconsistent enforcement of EMTALA and confusion among medical practitioners.[58]

D. STATE HISTORY AND LEGISLATION

California continues to struggle with patient dumping committed by hospitals both within the state and out. Recent investigations indicate that out-of-state facilities such as Rawson-Neal have dumped over 400 patients in California over the past five years.[59] The Sacramento Bee reported that as of 2008, approximately twenty-four patients were dumped in San Francisco alone.[60] Twenty of those patients required emergency medical services upon arrival, costing taxpayers $500,000 in medical expenses for these nonresidents.[61]

The city of Los Angeles also has a history of patient dumping. Earlier this year, the Los Angeles City Attorney opened investigations into patient dumping incidences on Skid Row.[62] City Attorney Mike Feuer challenged Beverly Hospital about alleged patient dumping.[63] According to the Los Angeles Times, Beverly Hospital engaged in patient dumping when it sent a patient in a one-way taxi to Skid Row.[64] Feuer commented that "patient

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[55] John Cotc, *Nevada Could Face Suit for Dumping Patients in Calif.*, SF GATE, Aug. 20, 2013, http://www.sfgatc.com/bayarca/article/Ncvada-could-facc-suit-for-dumping-patients-in-4745151.php.

[56] *See infra* Section III.

[57] *See infra* Section III.

[58] *See infra* Section III.

[59] Cynthia Hubert & Phillip Reese, *San Francisco Sues Nevada over 'Patient Dumping'*, THE SACRAMENTO BEE, Feb. 4, 2014, http://www.sacbee.com/2013/ 09/10/5723995/san-francisco-files-class-action.html.

[60] *Id.*

[61] *Id.*

[62] Richard Winton & Cara Mia DiMassa, *L.A. Files Patient 'Dumping' Charges*, LOS ANGELES TIMES, Nov. 16, 2006, http://articles.latimes.com/2006/nov/16/ local/me-dumping16.

[63] Richard Winton, *Montebello Hospital Accused of Dumping Homeless Patient Will Pay Fine*, LOS ANGELES TIMES, Jan. 3, 2014, http://articles.latimes.com/2014/jan/03/local/la-me-ln-patient-dumping-skid-row-20140103.

[64] *Id.*

dumping is inhumane and intolerable."[65] Part of his message included a $250,000 fine for the hospital.[66] Beverly Hospital agreed to this settlement rather than face criminal charges.[67] Although this case marks the first time in several years that a hospital has been caught patient dumping on Skid Row, its practice in Los Angeles has increased.[68] In an interview with southern California public radio station KPCC, City Attorney spokesman Frank Matlejan commented, "[t]here was a lull there [on Skid Row] for a while, but we have seen an increased number of alleged incidents [of patient dumping] that were allegedly occurring on Skid Row."[69] The Los Angeles Times and KPCC found that hospitals all over southern California, including Alhambra Sanatorium and Costa Mesa Hospital, continue to dump individuals on Skid Row.[70] Matlejan also noted that patient dumping cases "are difficult to prove because you have victims that are very transient and hard to identify."[71]

The California legislature has enacted measures to assist in reducing incidences of patient dumping, but these measures fall victim to the same inefficiencies as EMTALA. For example, effective January 1, 2008, California's Health and Safety Code section 1317 requires that "[e]mergency services and care shall be provided to any person requesting the services or care, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter."[72] However, similar to EMTALA, the code lacks a clear definition of key terms, such as emergency condition.[73]

Additionally, efforts to curb patient dumping in California are hampered by the state's medical malpractice statute, the Medical Injury Compensation Reform Act ("MICRA").[74] MICRA establishes a cap of $250,000 on victims' claims for noneconomic losses attributable to the

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[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] Hayley Fox, *Los Angeles City Attorney Investigating New Cases of Possible Skid Row 'Patient Dumping'*, SOUTHERN CALIFORNIA PUBLIC RADIO, http://www.scpr.org/news/2013/10/08/39601/los-angeles-city-attorney-investigating-patient-du/ (last visited Aug. 8, 2014).

[70] *Id.*; Winton & DiMassa, *supra* note 62.

[71] Fox, *supra* note 69.

[72] CAL. HEALTH & SAFETY CODE § 1317(a) (2014).

[73] *See* Treiger, *supra* note 5, at 1202.

[74] CAL. CIV. CODE § 3333.2(b) (2014).

negligence of a health care provider.[75] Many individuals choose to litigate patient dumping violations through MICRA because an individual need prove negligence only, rather than knowledge of an emergency medical condition.[76] Despite the lower threshold of evidence necessary, many people are deterred from this avenue of litigation because of the cap on damages.[77]

III. LITIGATION: AN IMPERFECT SOLUTION?

This section analyzes three avenues of relief for victims of patient dumping: EMTALA enforcement actions by individual victims, state based avenues of relief, and reimbursement actions by victims and localities where patients are dumped. For the most part, actions for relief under these avenues have failed to protect victims of patient dumping.

A. EMTALA

EMTALA was enacted in 1986 to combat patient dumping.[78] However, due to ambiguity in the legislation, the act has been ineffective in reducing the number of patient dumping incidences. Specifically, as discussed in Section II, key terms within EMTALA, such as appropriate medical examination and emergency medical condition, have been subject to varying interpretations, which has led to inconsistent and ineffective enforcement of the statute.[79]

EMTALA states that "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition . . . exists."[80] An emergency medical condition exists

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[75] *Id.*

[76] *See infra* Section III.

[77] *See infra* Section III.

[78] H.R. REP. NO. 99-241, pt. 3, at 5 (1985).

[79] Gionis, Camargo, Jr. & Zito, Jr., *supra* note 8, at 213–14; *see also* Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 455 (1994) ("Although considerable ambiguity exists concerning what constitutes an 'appropriate medical screening examination,' courts have yet to require a full treatment examination or an examination that meets the standard of the reasonable doctor. A routine triage examination probably suffices.").

[80] 42 U.S.C. § 1395dd(a) (2012); *see also* CTR. FOR MEDICARE AND MEDICAID SERVS., STATE OPERATIONS MANUAL APP. V 36 (1998) *available at* http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ som107ap_v_emerg.pdf ("[A medical screening examination] is the process required to reach, with reasonable clinical confidence, the point at

when:

> a medical condition manifest[s] 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 placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[81]

The Ninth Circuit stated, "[T]he plain language of EMTALA informs us that a medical screening examination is appropriate if it is designed to identify *acute* and *severe* symptoms that alert the physician of the need for *immediate* medical attention to prevent serious bodily injury."[82] On the other hand, the Sixth Circuit held that if a nonpaying patient is treated the same as a paying one, then the treatment was appropriate.[83] The court stated that if the hospital acts in the "same manner as it would have for the usual paying patient, then the screening provided is appropriate within the meaning of the statute."[84] Furthermore, the OIG has stated that some parts of EMTALA are unclear, citing specifically to the terms emergency medical condition and medical screening exam.[85]

Varying interpretations of these key terms are illustrated in the following cases. In *Eberhardt v. City of Los Angeles*, a father of a decedent sued a treating hospital for violating EMTALA when the hospital discharged the decedent in an unstable condition.[86] The decedent was admitted to the hospital with a drug overdose, and stated that he feared "impending doom" and was angry that the hospital had saved his life.[87] The court reasoned that there was no condition that, by itself, manifested symptoms severe enough to indicate that the decedent's health was in jeopardy.[88] The court stated that the hospital conducted an appropriate medical examination, which consisted of a physical examination and

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which it can be determined whether [an individual] has an [emergency medical condition] or not. . . . If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an [emergency medical condition] exists, it has met its obligations under the EMTALA.").

[81] 42 U.S.C. § 1395dd(e)(1).

[82] Eberhardt v. City of L.A., 62 F.3d 1253, 1257 (9th Cir. 1995) (alteration in original) (internal quotation marks omitted).

[83] Cleland v. Bronson Health Care Grp., Inc., 917 F.2d 266, 272 (6th. Cir. 1990) (internal quotation marks omitted).

[84] *Id.*

[85] SURVEY, *supra* note 50, at 13.

[86] *Eberhardt*, 62 F.3d at 1254.

[87] *Id.* at 1255.

[88] *Id.* at 1257.

stabilizing medication, but no mental examination.[89] The court noted that this examination was appropriate because the hospital applied a method of screening within its capacity, and because the hospital treated similarly situated patients equally.[90] Thirty hours after being discharged from the emergency room following his appropriate medical screening, the decedent charged at police officers while holding a gun and screaming "kill me" and "put me out of my misery."[91] The decedent was shot and killed by the police officers.[92]

Another similar case, *Jackson v. East Bay Hospital*, found that a hospital had not violated EMTALA, even though a decedent came to the emergency room multiple times stating that he was mentally ill and having trouble breathing, and he was found to have traces of antidepressants in his urine, was given no medication or examination for his apparent illness, and died from the toxicity of antidepressants in his system.[93] After being discharged from the hospital for a second time, the decedent's wife found him walking the streets in the middle of the night.[94] She brought him back to the emergency room stating that she feared he was suicidal.[95] Again, the treating physician suggested that the decedent take medication to stabilize his agitation and that he enter a local psychiatric ward, but did not treat him for any suicidal tendencies or mental illness.[96] Upon reaching the closest psychiatric ward later that afternoon, the decedent died from antidepressant toxicity.[97] The court stated that the hospital did not violate EMTALA, and that it provided the decedent with an appropriate medical screening, even though the medical screening did not detect any emergency condition, or any symptoms that indicated his health was in jeopardy.[98]

As these cases demonstrate, there is no universally accepted definition or set of procedures to determine whether a hospital or physician provided an appropriate medical screening. This is problematic because the way in which a court chooses to define an appropriate medical screening determines whether or not there may be an emergency medical condition, and consequently, whether a hospital has engaged in patient

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[89] *Id.* at 1257–58.
[90] *Id.* at 1258.
[91] *Id.* at 1255.
[92] *Id.* at 1254.
[93] Jackson v. East Bay Hosp., 246 F.3d 1248, 1252–53 (9th Cir. 2001).
[94] *Id.* at 1253.
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.* at 1256–57.

dumping. Therefore, it is crucial that these terms be defined more precisely and consistently.

In 2003, the Department of Health and Human Services ("DHHS") and CMS took steps to further define certain terms in EMTALA.[99] For example, Section 489.24 of the Code of Federal Regulations redefined a few terms.[100] These amendments provided clarity on particular terms, such as "comes to the emergency room," but left other important terms, such as emergency medical condition, unaltered.[101] Thus, these regulations did not make EMTALA a significantly more powerful tool in combatting patient dumping.

B. STATE LAW AS AN AVENUE OF RELIEF

Given the inconsistent interpretation and enforcement of EMTALA, many individuals turn to state law for relief from patient dumping. The main avenues of state law relief include medical malpractice claims and MICRA. However, as discussed in Section II above, these avenues of relief contain elements that make them as ineffective as EMTALA.

In order to bring a successful case under California's antidumping statute, a victim must prove that the treating physician was aware of an emergency medical condition and failed to stabilize the individual prior to discharge.[102] This is similar to EMTALA's requirement that the treating physician must find that an emergency medical condition exists for there to be a duty to stabilize.[103] Because these two requirements are similar in nature, bringing a claim under section 1317 or EMTALA presents the same challenges of proving knowledge of an emergency medical condition after an appropriate medical examination.

Alternatively, MICRA requires that each individual prove negligence in order to assert a successful claim.[104] Negligence is determined by an objective reasonable person standard and takes into consideration testimony of experts in the medical field.[105] This differs from EMTALA,

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[99] Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 432, 489).

[100] 42 C.F.R. § 489.24(b) (2014).

[101] *Id.*

[102] *See* Fox, *supra* note 69.

[103] *See* Brooker v. Desert Hosp. Corp., 947 F.2d 412, 415 (9th Cir. 1991) ("Section 1317 is California's version of 42 U.S.C. § 1395dd . . . .").

[104] CAL. CIV. CODE § 3333.2(a) (2014).

[105] *Id.* § 3333.2(c)(2).

which requires an individual to prove that the treating physician had knowledge of an emergency medical condition after an appropriate medical screening but prior to dumping the individual.[106] Unfortunately, MICRA imposes a $250,000 cap on how much an individual can claim in noneconomic damages.[107] This could, and likely does, discourage many individuals from pursuing a claim under MICRA. Furthermore, given that some ETMALA claims do involve elements of negligence, in appropriate cases, courts may apply MICRA in conjunction with EMTALA to limit the amount of noneconomic damages an individual receives for a claim brought under EMTALA.[108]

Barris v. County of Los Angeles is an excellent example of when MICRA and EMTALA are applied together.[109] In that case, the mother of an eighteen-month-old decedent was awarded over $1 million in noneconomic damages at trial against a county after her daughter was discharged from an emergency room before being properly stabilized.[110] The mother brought the decedent to the emergency room by ambulance with symptoms of vomiting, diarrhea, and labored breathing.[111] A doctor who examined the decedent feared she had a bacterial infection in her bloodstream.[112] The doctor treated the decedent's symptoms, but did not prescribe any antibiotics because the decedent was covered by the Kaiser Foundation Health Plan.[113] The doctor transferred the decedent to the local Kaiser Hospital believing that blood tests would be conducted there.[114] However, shortly after the transfer, the decedent suffered from cardiac arrest and died.[115] Expert testimony at trial indicated that, not only should the decedent have been provided with antibiotics in order to stabilize her symptoms, but that her transfer jeopardized her health.[116] Furthermore, the superior court found that MICRA applied in conjunction with EMTALA and, thus reduced the plaintiff's noneconomic damages from over $1 million to $250,000.[117] The Supreme Court of California affirmed this

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[106] 42 U.S.C. § 1395dd(a) (2012).
[107] CAL. CIV. CODE § 3333.2(b).
[108] Barris v. Cnty. of L.A., 972 P.2d 966, 968 (1999).
[109] *Id.*
[110] *Id.*
[111] *Id.* at 969.
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.* at 969–970.
[117] *Id.* at 970.

decision.[118]

Although MICRA has the potential to allow victims of patient dumping to circumvent EMTALA, the cap of $250,000 for noneconomic damages can deter individuals from bringing claims under it. Additionally, the fact that this statute can be applied in conjunction with EMTALA subjects multiple avenues of relief to the same $250,000 cap.

C. REIMBURSEMENT CASES: ACTIONS TO ENJOIN

Both EMTALA actions and state avenues of relief have proved somewhat ineffective in deterring hospitals and individuals from engaging in patient dumping. As a result, attorneys have turned to innovative causes of action to seek reimbursement for patient dumping. Although not all of these cases have been successful, they may provide a new avenue of relief that brings potential and hope for victims of patient dumping.

Recently, attorneys in Nevada and San Francisco have used innovative causes of action to seek reimbursement for patient dumping. Some causes of action include civil rights claims and basic common law misappropriation. More specifically, two recent class actions, *Brown v. Rawson-Neal*, and *City and County of San Francisco v. Nevada*, have sought reimbursement and injunctions for victims of patient dumping.

On June 11, 2013, the American Civil Liberties Union ("ACLU") of Nevada filed a class action lawsuit against Rawson-Neal Psychiatric Hospital in Federal Court in Nevada, with James Flavy Coy Brown as the named plaintiff.[119] The represented class consisted of those who, like Brown, are:

> psychiatric patients in need of mental health services who were or, unless

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[118] *Id.* (discussing how state law requires a showing of negligence and EMTALA requires a determination that the patient was suffering from an emergency medical condition, but also that a hospital need provide treatment to stabilize a patient only). "[A]n EMTALA claim based on failure to provide medically reasonable treatment to stabilize a patient would, if brought under state law, constitute a claim of 'professional negligence' as defined by Civil Code section 3333.2. The EMTALA claim for failure to stabilize has additional, but no inconsistent, elements. Thus, the medical causation proof required to establish an EMTALA claim that a hospital failed to provide medical treatment to assure, within reasonable medical probability, that the patient's condition would not materially deteriorate is the same as that which would be required to prove 'a negligent act or omission to act by a health care provider . . . which . . . is the proximate cause of personal injury or wrongful death.'" *Id.* at 974 (quoting CAL. CIV. CODE § 3333.2 (2014)).

[119] Class Action Complaint for Injunctive and Declaratory Relief and Damages Under the Eighth and Fourteenth Amendments; 42 U.S.C. § 1983, and Supplemental State Claims; Demand for a Jury Trial, Brown v. S. Nev. Adult Mental Health Servs., No. 2:13-CV-1039 JCM (PAL) (D. Nev. July 24, 2014), 2014 WL 3721339 *available at* http://aclunv.org/files/brownvrawsonneal-complaint.pdf.

> the practices are enjoined preliminarily and permanently, will be involuntarily discharged from defendant Rawson-Neal and then required to travel by Greyhound bus or equivalent transportation modes to out-of-State destinations without their competent consent; and without arrangements having been first made for the continuation of their treatment; and without arrangements for follow-up care.[120]

The plaintiffs sought an injunction against these practices, a declaratory judgment that the defendant was in violation of their rights under the United States Constitution and Nevada state law, as well as compensatory and punitive damages in an amount according to proof.[121]

The complaint in *Brown v. Rawson-Neal* contains nine causes of action.[122] The most innovative causes of action are the civil rights claims, namely that the defendants violated the due process and equal protection rights of the plaintiff class when they discharged them from Rawson-Neal and sent them to out-of-state destinations where the defendant knew these plaintiffs would be unable to obtain adequate treatment and housing.[123] The plaintiffs asserted that they were denied due process when they were prevented from meaningfully challenging their involuntary discharges and compelled to be transferred from Rawson-Neal.[124] The Fourteenth Amendment equal protection claim asserts that the defendants treated indigent patients such as Brown differently by sending them out of state on Greyhound buses, while retaining or arranging appropriate forms of discharge for patients who were not indigent.[125] The complaint further states that the defendant intended to single out indigent patients to deprive these individuals of their right to equal psychiatric and medical care.[126]

U.S. District Court Judge James Mahan dismissed the case with leave to amend.[127] Judge Mahan stated that the complaint did not properly allege that the plaintiffs were compelled to leave the state of Nevada.[128] Rather,

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[120] *Id.* at 9.

[121] *Id.* at 20.

[122] *Id.* at 12–19.

[123] *Id.* at 13.

[124] *Id.* at 12.

[125] *Id.* at 13–14.

[126] *Id.* at 13.

[127] Brown v. S. Nev. Adult Mental Health Servs., No. 2:13-CV-1039 JCM (PAL) 2014 WL 3721339, at *3 (D. Nev. Feb. 13, 2014), *cert. denied*, 2014 WL 2807688; Ken Ritter, *Federal Judge Dismisses Lawsuit in Nevada 'Patient Dumping' Case*, LAS VEGAS SUN, Feb. 13, 2014, http://www.lasvegassun.com/ news/2014/feb/13/federal-judge-dismisses-lawsuit-nevada-patient-dum/.

[128] Ritter, *supra* note 127.

the complaint provided evidence indicating that the defendants provided them with the means to leave the state, but did not force them to leave.[129] Judge Mahan further stated that the plaintiff's arguments were "nonsensical."[130] Although using these causes of action gives individuals a way to circumvent EMTALA and state medical malpractice law, the disposition of this case showed that proving that one hospital intentionally dumped patients and the cost of their care onto another is challenging.[131] Despite the unfortunate series of events that took place in Nevada, other class actions continue to make strides for victims of patient dumping.

On September 10, 2013, San Francisco City Attorney Dennis Herrera filed a suit in San Francisco Superior Court against the state of Nevada.[132] The action was filed on behalf of all California local governments that have received indigent patients who were improperly bused from Rawson-Neal Hospital.[133] Herrera claims that as of 2008, over two dozen patients have been transported to San Francisco, with twenty of them requiring medical care shortly after arrival.[134] The plaintiffs sought an injunction prohibiting the defendant from transferring patients to California, unless they reside there, as well as damages and restitution.[135] The main causes of action are misappropriation, unjust enrichment, and a violation of a Nevada statute.[136] Under the misappropriation claim, the plaintiffs asserted that they have invested a substantial amount of public resources into creating programs to provide health care, shelter, and housing to indigent residents of San Francisco.[137] The defendant allegedly misappropriated these public resources by sending nonresident indigent individuals, who have no family or caretakers, from Nevada to San Francisco.[138]

The plaintiffs also argued that the city of San Francisco should be given restitution damages for the dumped patients.[139] If Rawson-Neal had

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[129] *Id.*

[130] *Id.*

[131] Hubert & Reese, *supra* note 59.

[132] Complaint for Damages, Equitable, and Class-wide Declaratory and Injunctive Relief at 1, City & Cnty. of S.F. v. Nevada, No. CGC-13-534108 (Sept. 10, 2013) [hereinafter Complaint for Damages] *available at* http://www.sfcityattorney.org/modules/showdocument.aspx?documentid=1343.

[133] *Id.* at 10.

[134] *Id.* at 9.

[135] *Id.* at 16–17.

[136] *Id.* at 13–16.

[137] *Id.* at 13.

[138] *Id.*

[139] *Id.* at 3.

not put these individuals on a bus and sent them to San Francisco, they would likely have received care from the defendants or another public hospital in Nevada.[140] By patient dumping, the defendants avoided these costs, and shifted them to the plaintiff.[141] Furthermore, the plaintiff claimed that absent injunctive relief, the defendants would continue these practices to the detriment of the plaintiffs.[142]

The plaintiffs claimed a violation of Nevada state law under revised statute section 428.010, because under that section Nevada is required to provide care, support, and relief to the poor, indigent incompetent, and those incapacitated by age, disease, or accident who are Nevada residents.[143] The plaintiffs contended that in transporting such indigent persons, who suffer from mental illness and require ongoing medical care, to California, Nevada has shifted its duties and responsibilities to the city of San Francisco, thereby violating section 428.010.[144]

Nevada has yet to answer the complaint,[145] and instead claimed that the court lacked jurisdiction.[146] Shortly after filing the complaint, City Attorney Herrera received a letter from the Nevada Chief Deputy Attorney General, Linda C. Anderson, which referred to the case and discussed how hundreds of California residents were treated at Rawson-Neal between 2008 and 2013.[147] More specifically, the letter stated:

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[140] *Id.* at 2.

[141] *Id.* at 14.

[142] *Id.*

[143] Complaint for Damages, *supra* note 132, at 15; *see also* NEV. REV. STAT. § 428.010 (2014). "Except as otherwise provided in NRS 422.382, to the extent that money may be lawfully appropriated by the board of county commissioners for this purpose pursuant to NRS 428.050, 428.285 and 450.425, every county shall provide care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident, lawfully resident therein, when those persons are not supported or relieved by their relatives or guardians, by their own means, or by state hospitals, or other state, federal or private institutions or agencies." NEV. REV. STAT. § 428.010(1). "Except as otherwise provided in NRS 439B.330, the boards of county commissioners of the several counties shall establish and approve policies and standards, prescribe a uniform standard of eligibility, appropriate money for this purpose and appoint agents who will develop regulations and administer these programs to provide care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident." *Id.* § 428.010(2).

[144] *Id.* at 15–16.

[145] Joint Case Management Statement at 2, City & Cnty. of S.F. v. Nevada, No. CGC-13-534108 (Sept. 5, 2014) *available at* http://webaccess.sftc.org/scripts/magic94/Mgrqispi94.dll?APPNAME=web&PRGNAME=casenumberprompt22 (enter 534108 into the search bar, then follow the link of the proceeding dated on Sept. 5, 2014).

[146] *Id.* at 1.

[147] Romney, *supra* note 16.

> [T]he taxpayers of the State of Nevada have subsidized the State of California over $6.2 million during this same period. Since both California and Nevada are financially impacted by the travel of individuals with mental illness between our states, we believe that government officials would benefit from better communication and collaboration . . . rather than trying to allocate financial responsibility through litigation.[148]

Furthermore, when the complaint was filed, Rawson-Neal had lost its accreditation by the Joint Commission as a result of its busing practice, and it had failed one inspection by CMS.[149] Rawson-Neal will lose its federal funding if it fails another ongoing inspection.[150]

It is difficult to predict how this class action will proceed, given that the parties have spent the past several months disagreeing over issues like jurisdiction.[151] Additionally, the recent ruling by District Court Judge James Mahan raises concern over the future of this case.[152] However, given that this class action brings forth different causes of action, if the plaintiffs can substantiate their claims with relevant evidence, misappropriation and restitution can be proven.

While cases under EMTALA, state law, and reimbursement actions are important in combating the issue of patient dumping, they do not provide the entire solution. The inconsistent interpretation of key terms within EMTALA has allowed repeat offenders to continue dumping unstable individuals without providing appropriate relief.[153] The same occurs under state law, and, unfortunately, introduces a cap on noneconomic damages available to each individual bringing a claim.[154] Furthermore, innovative causes of action, such as civil rights claims and common law misappropriation claims have the potential to create change, but have also been subject to challenge.[155] Therefore, although litigation is helpful in reducing incidences of patient dumping, it should be combined with other elements such as legislative amendments, raising awareness

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[148] *Id.*

[149] *Id.*; Andrew Doughman, *Rawson-Neal Hospital Could Lose Crucial Medicare Funding*, LAS VEGAS SUN, Aug. 9, 2013, http://www.lasvegassun.com/news/2013/aug/09/rawson-neal-could-lose-crucial-medicare-funding/.

[150] Romney, *supra* note 16.

[151] Joint Case Management Statement, *supra* note 145, at 1 (noting that Nevada has contested jurisdiction while individual parties have also challenged that service was improper.)

[152] Ritter, *supra* note 127.

[153] *See* Doughman, *supra* note 149 (noting that Rawson-Neal only received notice from CMS in 2013 after years of patient dumping).

[154] CAL. CIV. CODE § 3333.2(b).

[155] Joint Case Management Statement, *supra* note 145, at 1.

about patient dumping, and a new look at the Affordable Care Act to create a durable solution.

IV. LITIGATION AND MORE CAN LEAD TO SUCCESS

A. AMENDING EMTALA

Though EMTALA was enacted to combat patient dumping,[156] it has not been successful. Ambiguities and loopholes in the legislation have led to ineffective enforcement and, in part, are responsible for increased patient dumping. Congress should amend EMTALA to include more specific definitions for key terms such as emergency medical condition and appropriate medical screening. Defining standards more precisely will offer clarity to medical care providers and will allow individuals whose rights have been violated to more easily file suits.

EMTALA should also be a federally funded mandate. Many individuals are dumped because stabilizing mentally ill or indigent patients prior to discharge is too costly.[157] Often these individuals require long-term care to effectively stabilize their condition.[158] If EMTALA provides hospitals with funding to treat patients who are mentally ill or indigent, perhaps there will be less incentive to dump them.

EMTALA should also be enforced more stringently. Rawson-Neal has violated legal standards on multiple occasions, yet CMS has not withdrawn any of the $3.2 million in Medicare and Medicaid funding it provides to the hospital on an annual basis.[159] Congress should enforce more thorough site checks, accompanied by active consequences. In order to reduce incidences of patient dumping, it is imperative that the proper authorities hold violators accountable for their actions.

B. RAISING AWARENESS

Raising awareness about patient dumping is another avenue that could be helpful in reducing incidences of patient dumping. Supporting

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[156] *See* H.R. Rep. 99-241, pt. 1, at 4 (1985) ("The transfer of a patient with an unstable emergency medical condition would be prohibited unless (1) the benefits of the transfer outweigh the risks, and (2) the transfer is an appropriate transfer (that includes the transfer of appropriate documents) and is accomplished in an appropriate manner.").

[157] *See* Gionis, Camargo & Zito, *supra* note 8, at 184–85 (noting that hospitals have a financial incentive to dump patients when they cannot pay for their care).

[158] Complaint for Damages, *supra* note 132, at 6.

[159] Cote, *supra* note 55.

advocacy groups in educating others about how often patient dumping occurs, how to combat it, and how to provide protection to victims of patient dumping can serve as a powerful tool for not only preventing patient dumping in the long term, but in placing this issue on the political agenda. Examples of how individuals can raise awareness about patient dumping are reflected in the ACLU of Nevada's efforts in taking up a class action case focused on this very issue.[160] Additionally, there are other organizations that continue to raise awareness of the issue around the country.[161] For example, news agencies such as the Sacramento Bee and the Los Angeles Times have reported on the matter and raised awareness.[162] These efforts have been pivotal in raising awareness about patient dumping, but even more is needed to enact lasting change.

C. AFFORDABLE CARE ACT

The Affordable Care Act ("ACA") was signed into law on March 10, 2010.[163] The act aims to create significant change in the health care system in order to provide more individuals with health care insurance and coverage.[164] Specifically, the ACA states that "[n]ot later than [ninety] days after March 23, 2010, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014."[165]

Prior to the ACA, most public health care benefits fell under a mixture of Medicaid, Medicare, or veteran's or children's benefits.[166] With

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[160] *See* Steve Tetreault, *Nevada Flaws Aired at 'Patient-Dumping' Session*, LAS VEGAS REVIEW JOURNAL, March 14, 2014, http://www.reviewjournal.com/news/ nevada-flaws-aired-patient-dumping-session (illustrating how the Sacramento Bee investigation of Rawson-Neal helped lead to a hearing before a federal civil rights panel).

[161] Hubert, *supra* note 2; Romney, *supra* note 16.

[162] Hubert, *supra* note 2; Romney, *supra* note 16.

[163] Patient Protection and the Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

[164] *Id.*; *see also* JULIET BRODIE, CLARE PASTORE, JEFFREY SELBIN & EZRA ROSSER, POVERY LAW, POLICY, AND PRACTICE 7–52 ("The health reform law, the most significant social legislation in the U.S. since 1965, seeks to eliminate large and growing gaps in health insurance by increasing access to affordable coverage and instituting a new legal obligation on the part of individuals to obtain it." (citing THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER 11 (2013) *available at* http://kaiserfamilyfoundation.files.wordpress.com/ 2010/06/7334-05.pdf)).

[165] 42 U.S.C. § 18001 (2012).

[166] *Medicaid, CHIP, and Medicare*, HEALTHCARE.GOV, https://www.healthcare.gov/other-health-insurance-programs/ (last visited Aug. 25, 2014) (listing different government health

the ACA, these forms of health care benefits continue to exist and will expand to include more people.[167] Specifically, the Medicaid eligibility requirements will be expanded to include individuals whose income is less than 138 percent of the poverty line.[168] Prior to 2013, only individuals whose income was below the poverty line were eligible for most Medicaid benefits.[169]

Expanding coverage affects patient dumping because prior to the ACA, most victims of patient dumping were not eligible for Medicaid because they did not fall within the categories to be enrolled, such as being elderly, disabled, or caring for children.[170] However, because the ACA eliminated these eligibility requirements, victims of patient dumping who did not qualify for health insurance before may now obtain basic coverage.[171] The ACA creates an incentive for physicians to treat patients and stabilize them prior to discharge, since there will be more insured individuals, and fewer uncollectable bills.[172] Thus, these changes have the potential to significantly reduce incidences of patient dumping, so many of which are inextricably linked to an individual's economic status.[173]

V. CONCLUSION

Patient dumping continues to be a widespread problem in the United States. Despite legislation and litigation to remedy the issue, incidences of

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insurance programs).

[167] *See Medicaid Expansion & What it Means for You*, HEALTHCARE.GOV, https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicaid/ (last visited Oct. 14, 2014) (noting that Medicaid is expanding its coverage in some states).

[168] *Id.* (discussing how the Affordable Care Act provides insurance to individuals whose income is less than 133 percent of the poverty line, which, because of the way it is calculated, is equivalent to 138 percent of the federal poverty line).

[169] *See Medicaid Expansion & What it Means for You*, *supra* note 167 (noting that some states have not changed the eligibility requirements for Medicaid and still require a family's income to be below the poverty line to be eligible).

[170] *Qualifying for Medicaid Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/do-i-qualify-for-medicaid/ (last visited Aug. 25, 2014).

[171] *Medicaid Expansion & What it Means for You*, *supra* note 167; *see also* Benjamin D. Sommers et al., *Health Reform and Changes in Health Insurance Coverage in 2014*, 371 NEW ENG. J. MED. 867, 871 (2014) ("[T]he uninsured rate declined by 5.2 percentage points by the second quarter of 2014 . . . .").

[172] Gionis, Camargo, & Zito, *supra* note 8, at 184–86 ("Increases in the number of uninsured individuals have caused a significant strain on the ability of hospitals and physicians to provide care to the indigent while remaining solvent. With an increase in the number of uninsured individuals, there has been a documented increase in the number of patients being dumped.").

[173] *Id.*

patient dumping continue to rise. In a recent departure from usual patient dumping litigation, the ACLU of Nevada and the City Attorney for San Francisco have utilized new and innovative causes of action to help seek justice for victims of patient dumping, both patients and cities. Although litigation under EMTALA and using innovative causes of action are working to reduce patient dumping, there are additional elements that are necessary to achieve a sustainable solution. Federal and state governments should focus on amending legislation to improve clarity, raising awareness of patient dumping, and understanding the impact that the ACA may or may not have in the future. Although these actions cannot guarantee a solution to patient dumping, taking these proactive steps, in conjunction with litigation, can help lead to a more sustainable and effective solution.

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VOLUME 24 NUMBER 2 SPRING 2015

SOUTHERN CALIFORNIA REVIEW OF LAW AND SOCIAL JUSTICE

ARTICLE

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NOTES

UNIVERSITY OF SOUTHERN CALIFORNIA
Gould School of Law

Southern California Review of Law and Social Justice (ISSN 1088-3525)
is Published Three Times Annually by the Students of the
University of Southern California
Law School
699 Exposition Blvd.
Los Angeles, California 90089-0071
Phone: (213) 740-5696
E-mail: rlsj@lawmail.usc.edu
Website: http://law.usc.edu/students/orgs/rlsj/index.cfm

POSTMASTER: Send address changes to *Southern California Review of Law and Social Justice*, University of Southern California Law School, 699 Exposition Blvd., Los Angeles, California 90089-0071.

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VOLUME 24 2014–2015