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Emergency! Says Who?: Analysis of the Legal Issues Concerning Managed Care and Emergency Medical Services

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It is the middle of the night and you wake up with pain in your chest; you think you are having a heart attack. Although you are a member of a managed care organization ("MCO"), you do not contact your MCO. Instead, you go directly to an emergency room for treatment. Ultimately tests show that there was no heart attack, but rather just heart-burn. Will your MCO pay for the emergency service rendered in this scenario? It appears that in a significant number of instances the answer is no. In some cases, MCOs have denied payment for a member's care because tests at the emergency room found there was no emergency, or because, according to the MCO's definition of emergency, there was no emergency. In other cases, payment was denied because the MCO member

1. See Charles S. Clark, *Emergency Medicine*, 6 CQ RESEARCHER 3 (relating that most MCOs inform their members that "failure to contact a primary-care physician prior to emergency treatment may result in denial of payment"); E.B. Boyd, *Emergency Care Can Be Costly: Managed Care Plans Manage to Have E.R. Bill Sent to Subscriber*, Pitts. POST-GAZETTE, Mar. 11, 1996, at A-7 (reporting that most managed care companies require a member to get permission to go to an emergency room if there is no "danger to life or limb," and that members risk nonpayment if the MCO's procedures are not followed); *Testimony July 27, 1995 Richard C. Aghababian*, M.D., President American College of Emergency Physicians, House Ways and Means Health Plans Under Medicare, FED. DOCUMENT CLEARING HOUSE July 27, 1995, available in 1995 WL 446710 [hereinafter *Testimony*]. Dr. Aghababian stated, while testifying about the problems concerning emergency medical care in the age of managed care, that the area of medical care most subject to payment disputes of Medicare enrollees is emergency medical services; 40% of such disputes involved "in-area" emergency care, while another 20% were for "out-of-area" emergency care. *Id.*


3. See Vicki A. Baldassano, *MCOs, Emergency Room Doctors at Odds Over Coverage of Urgent Care*, 4 Health L. Rep. (BNA) 1545 (Oct. 12, 1995) (reporting that in some cases MCOs fail to authorize emergency medical care for conditions the plan does not classify as emergencies); *Who Decides if it's an Emergency*, *The Record*, Aug. 14, 1995, at
did not get required pre-authorization for the emergency service.\textsuperscript{4} Furthermore, payment has been denied where the MCO member sought emergency care from a hospital outside of the MCO network.\textsuperscript{5}

Public concern over such MCO payment denials,\textsuperscript{6} as well as questions about whether MCO members have adequate access to emergency medical service, has led to both state and federal legislative initiatives aimed at regulating the role of MCOs in emergency care.\textsuperscript{7} The managed care industry, on the other hand, has argued that there are no widespread problems concerning emergency medical care, and if there are any uneven spots, it is the market place, not the government, that is best suited to smooth them out.\textsuperscript{8}

This Comment will focus on the legal issues concerning emergency medical service in the age of managed care. First, an overview of the issues involving emergency medical service and managed care will be given. Next, historical problems concerning access to emergency medical service and the impact of managed care will be addressed.

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\textsuperscript{4} See Craig, supra note 2, at 136; infra, notes 29-31 and accompanying text (discussing gatekeeping method of requiring pre-authorization for medical care).

\textsuperscript{5} Id.

\textsuperscript{6} For example, USA Today reports that "[c]ritics say some [MCO] plans try to profit 'by refusing to pay for [emergency] care.'" Lori Sharn, Cost-Control Efforts Lead to Claim Disputes: Critics Say Some Health Plans Try to Profit 'by Refusing to Pay for Care,' USA TODAY, Aug. 22, 1995, at B1. An article in the New York Times notes that:

As enrollment in health maintenance organizations soars, hospitals across the country report that... [HMOs] are increasingly denying claims for care provided in hospital emergency rooms.... Dr. Stephan G. Lynn, director of emergency medicine at St. Luke's-Roosevelt Hospital Center in Manhattan, said: "We are getting more and more refusals by H.M.O.'s to pay for care in the emergency room. The problem is increasing as managed care becomes a more important source of reimbursement."


\textsuperscript{7} See Jan Ziegler, Behind the Scenes of the Managed Care Backlash, 14 BUS. & HEALTH 26, 28 (1996) (noting that in 1996 thirteen states passed emergency service laws). See also Milt Freudenheim, H.M.O.'s Cope With a Backlash on Cost Cutting, N.Y. TIMES, May 19, 1996, at 1 (reporting that twelve states have barred insurers "from refusing to pay for what turn out to be 'unnecessary' emergency room visits, when chest pains, for example, are traced to heartburn, not a life threatening heart attack").

With regard to federal legislation, see Clark, supra note 1, at 16 (discussing the Access to Emergency Medical Services Act originally introduced into the United States House of Representatives in 1995).

\textsuperscript{8} See infra notes 196-97 and accompanying text (discussing the free market approach to the regulation of emergency medical care).
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Emergency medical service is an expensive sector of the United States' health care industry. One recent estimate put its cost between twenty-five and thirty billion dollars per year. Emergency room care generally is thought to be much more expensive than care provided in a regular office visit, though this notion recently has been challenged. In addition, the passage of a federal statute that would set minimum standards for emergency medical coverage. Such a statute would eliminate the problem of ERISA preemption faced by the states in their regulatory efforts.

I. Overview

A. Emergency Medical Care: Cost and Payment Issues

Emergency medical service is an expensive sector of the United States' health care industry. One recent estimate put its cost between twenty-five and thirty billion dollars per year. Emergency room care generally is thought to be much more expensive than care provided in a regular office visit, though this notion recently has been challenged. In addition,
tion, there is also evidence of widespread abuse of emergency care, with unnecessary emergency room visits resulting in avoidable increased health care costs.\textsuperscript{14} Juxtaposed with the cost of emergency medical care is the fact that MCOs are put under tremendous pressure to counter spiraling increases in health care costs in the United States.\textsuperscript{15} Thus, the question of who will foot the bill for emergency medical care is of major importance to the health care industry's major players. Hospitals, through their emergency departments,\textsuperscript{16} MCOs,\textsuperscript{17} and MCO members,\textsuperscript{18} are among those that have the most at stake financially. Additionally, it has been suggested that the way in which MCOs are allowed to operate potentially could affect the continued existence of the emergency medical care system in the United States, which now includes hospital-maintained emergency rooms, open twenty-four hours a day.\textsuperscript{19}

In considering the payment issue, it is apparent that particular tension exists between hospitals and MCOs\textsuperscript{20} regarding payment for MCO mem-

\textsuperscript{14} The General Accounting Office ("GAO") estimated in 1993 that 43\% of visits to the emergency department were nonurgent. Clark, \textit{supra} note 1, at 6. \textit{But see} Helen Lippman, \textit{The Games Plans Play with ER Bills: Emergency Room Bills}, \textit{Bus. \& Health}, June 1996, at 20 (presenting the argument that the "more realistic" figure of inappropriate emergency care is 25\% to 30\%). It is suggested that the GAO figure did not allow for the "marginal or hard-to-distinguish cases." \textit{Id.} at 23). Note that taking the lowest figure of 25\% there are 23 million unnecessary visits to emergency rooms each year. \textit{Id.}

\textsuperscript{15} \textit{See} Pear, \textit{supra} note 6, at 22. \textit{See also} Bernice Caldwell, \textit{State Mandates on Managed Care Form 1996 Election Issues}, \textit{Employee Benefit Plan Rev.}, Aug. 1996, at 48, 48-54 (noting that managed care was "touted as the most promising" system to control "escalating costs"). Caldwell also proffers that managed care has, in fact, contained costs, but that the methods that MCOs have used to accomplish this have been so restrictive as to cause a public backlash. \textit{Id.}

\textsuperscript{16} In this Comment, "hospitals" refers to those hospitals that are not affiliated in any way with the MCO, for whose member the hospital emergency room provided care.

\textsuperscript{17} Throughout this Comment, MCO will be used to denote any managed health care organization, including Health Maintenance Organizations ("HMOs"), Preferred Provider Organizations ("PPOs"), and the like. See David E. Loder & Lisa Clark, \textit{Hospitals in Code-Blue Catch-22}, \textit{Nat'l L.J.}, Sept. 18, 1995, at B9 (noting that "'[m]anaged care organizations' is an umbrella term for the numerous types of delivery systems that are designed to manage members' medical care").

\textsuperscript{18} The term "MCO member" is used in this Comment to refer to any individual enrolled in a managed care organization.

\textsuperscript{19} \textit{See} Williams, \textit{supra} note 13, at 644 (suggesting that if emergency departments were reimbursed on the basis of just cost, a trend in the managed care industry, the emergency care system, which also services the uninsured, might fail to be financially viable).

\textsuperscript{20} The hospitals and MCOs as referred to in this Comment are unaffiliated with one another. This means that the hospital and MCO are independent entities and not in the same managed care system, or in any other partnership arrangement.
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ber emergency medical care rendered by hospital emergency departments. The hospitals and MCOs are intertwined in a relationship in which the hospital emergency department finds itself the provider of care for MCO members, while the MCO serves as payor. On the one hand, hospitals who receive Medicare funds and have emergency departments are required under federal law to provide screening and, if necessary, emergency medical service to all who show up at the emergency room. Some MCOs, however, have been accused of refusing reimbursement for their MCO members where such service was provided by the hospital emergency department. Critics suggest that MCOs sometimes are able to avoid their obligation to pay for MCO member emergency service by taking advantage of the complex, often confusing interaction between state and federal laws that regulate MCO coverage of emergency medical service.

B. Methods of MCO Cost Containment

To limit costs, MCOs utilize a practice called retrospective review which determines whether a medical procedure is covered after the procedure has been performed. Under this practice, a MCO may review emergency room care already received by a MCO member and then deny payment "for visits determined to be medically unnecessary." This retrospective denial of coverage is based on diagnostic tests showing that no emergency medical condition occurred. Recall the scenario in which the MCO refuses payment for a MCO member's emergency room care, after what was thought to be a heart attack, turned out to be heart-burn instead.

21. This is the situation where a MCO member is not receiving emergency medical service from the MCO itself, but rather through a nonaffiliated hospital emergency department. See Loder & Clark, supra note 17, at B9 (discussing the tension that is created when a hospital emergency room treats an MCO member, but the MCO is reluctant to, or fails to, pay for this service).


23. For discussions of how MCOs use federal law and EMTALA to deny payment for emergency care, see Mary Ellen Lloyd, ER Workers Lobby to Make HMOs Pay Fees: Emergency Charges Often Denied, THE CAPITAL, Feb. 28, 1996, at D1; Lippman, supra note 13, at 21; Pear, supra note 6, at 1, 22; Sharn, supra note 6, at 1; Loder & Clark, supra note 17, at B9.


26. Craig, supra note 2, at 136 (citation omitted).

27. Baldassano, supra note 3, at 1545.

28. Sharn, supra note 6, at 1; Kuttner, supra note 25, at C7.
“Gatekeeping” practices, which require pre-authorization for emergency services, may also be invoked by a MCO to deny payment for a member’s emergency medical care. The American College of Emergency Room Physicians (“ACEP”) has documented a number of specific examples where MCOs denied coverage for emergency care because the member failed to get prior-authorization from the MCO. In one case, a twenty-five year old went to the hospital emergency room after putting his hand through a window. Although the patient had bled profusely, coverage was denied because there was no referral. In another case, a sixty-four year old man went to a hospital emergency room with abdominal pain. Despite the fact that the MCO member was put into the intensive care unit and died within twenty-four hours after admission, the MCO denied his claim because he had not received a referral from his Primary Care Physician.

MCOs also have denied coverage when the MCO member did not use a pre-authorized emergency facility for emergency medical treatment; that is, when the MCO member went to a hospital outside of the MCO network.

Another way that MCOs control costs is to pay only for those emergency visits specifically defined as emergencies. While MCO members, based on their own experience, may in good faith be convinced they face a medical emergency, the MCO may not include that condition in its definition of emergency and deny payment on that basis. Thus, it would

29. See Edmund D. Pellegrino, M.D., Rationing Health Care: The Ethics of Medical Gatekeeping, 2 J. CONTEMP. HEALTH L. & POL’Y 23, 23 (1986) (describing gatekeeping as guarding society’s resources and cutting health care costs by conserving “tests, treatments, operations, hospitalization, and referrals for consultation”). Id. Pellegrino argues against the concept of gatekeeping as being “morally unsound and factually suspect.” Id. at 24.

30. Memo from Charlotte S. Yeh, M.D., F.S.C.E.P. to Jane Howell, American College of Emergency Physicians (Apr. 4, 1995) (distributed by American College of Emergency Physicians) (fax and accompanying memo on file with author). This and many other specific examples of similar situations have been documented by the American College of Emergency Physicians. Id.

31. Id.

32. Pear, supra note 6, at 1, 22.


34. See Pear, supra note 6, at 1, 22 (“Most [HMOs] promise to cover emergency medical services, but there is no standard definition of the term. [HMOs] can define it narrowly and typically reserve the right to deny payment if they conclude, in retrospect, that the conditions treated were not emergencies.”). Id.
It has been observed that "hospitals are put in an untenable position when MCOs refuse to pay for emergency room services." When an MCO refuses to pay for a member's emergency care, the cost shifts to the hospital that provided the care, even though the hospital may not be able to absorb the cost, or it is shifted to the individual MCO member, who also may find the expense impossible to absorb.

C. MCO Practices That Limit Access to Emergency Medical Care

Coupled with financial considerations, is public concern over adequate MCO member access to emergency medical care, as the United States witnesses the transformation of its health care system from a "fee-for-service medical delivery system," to a managed care system that emphasizes "pre-arranged care through certain physicians."

At issue are MCO practices and policies that limit a MCO member's access to emergency service, such as restricting or deterring the use of "911" emergency phone numbers. It has been reported that some MCOs actually try to dissuade MCO members from using the 911 emergency telephone service, thus exposing members to greater health risks. One study noted that it found only two out of sixteen MCOs located in a major metropolitan area that had instructed their subscribers to use the 911 paramedic system in the event of a medical emergency.

In both cases the member was directed to use the 911 number only after attempting to contact the MCO gatekeeper.

Another MCO practice of concern, which may have the effect of limiting MCO member access to emergency medical service, is "gatekeeping." It is reasonable to suggest that the threat of refusal to pay for non-preauthorized emergency care may deter a MCO member's use of

36. Baldassano, supra note 3, at 1546.
37. Id.
38. Id. at 1545.
39. Id.
40. Id.
42. Id.
43. See Craig, supra note 2, at 136 (general discussion of gatekeeping procedures). See also Pellegrino, supra note 29, at 23 (analyzing the ethical considerations of medical gatekeeping).
emergency services, thus effectively restricting access to treatment. However, the managed care industry argues that the practice of restricting a MCO member's access to emergency medical care is necessary in order to manage patient care effectively and reduce the cost of health care.\textsuperscript{44} Policies requiring preauthorization for emergency services, however, can be in direct conflict with a MCO member's unobstructed access to emergency medical care.\textsuperscript{45} One commentator has suggested that this is one of the "chief obstacles facing patients" seeking appropriate emergency medical care.\textsuperscript{46} An additional criticism includes the allegation that MCOs put members' health in danger by not providing twenty-four hour access to, or timely authorization for, emergency medical service.\textsuperscript{47}

II. THE HISTORICAL PROBLEMS OF ACCESS TO EMERGENCY MEDICAL CARE IN THE UNITED STATES

In order to understand the status of the current law, it is necessary to review the issues that helped to shape that law. Problems with patient access to medical care are not new in the United States. Congress recognized the problem of the inability of the indigent to obtain adequate medical care in 1946 when it passed the Hill-Burton Act.\textsuperscript{48} This Act was meant to give federal aid to hospitals so that they might be able to provide medical care to the indigent.\textsuperscript{49}

More recently, the tremendous expense of medical care in the United States, particularly emergency medical care, coupled with a significant and increasing uninsured population and compounded by an "increased focus by the health care industry on containing rising costs,"\textsuperscript{50} resulted in a practice known as "patient dumping."\textsuperscript{51} Patient dumping has been defined as "the denial of emergency medical services or the premature transfer of a patient from one hospital to another because the person

\textsuperscript{44} Craig, supra note 2, at 138.
\textsuperscript{45} See Baldassano, supra note 3, at 1545-46.
\textsuperscript{46} Id. at 1545.
\textsuperscript{51} Dobbertin, supra note 49, at 291 n.2.
cannot guarantee payment." In 1992, "it was estimated that thirty-six million Americans, fifteen percent of the population, did not have health insurance." The cost to private hospitals for care of this uninsured population led many to refuse to treat these patients and to unload them, primarily from their emergency rooms, to public hospitals. This practice significantly limited access to emergency medical service for those individuals who did not have medical insurance and were unable to pay for such service.

III. THE FEDERAL RESPONSE TO THE CRISIS OF INADEQUATE ACCESS TO EMERGENCY MEDICAL CARE

In 1986, Congress enacted EMTALA "as part of the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). This federal response to patient dumping is codified in section 1395dd of Title forty-two of the United States Code. EMTALA was created by Congress to eliminate patient dumping, and it "established specific standards for the evaluation, treatment, and transfer of patients." EMTALA mandated that "a hospital that has a hospital emergency department . . . must provide [an individual] . . . an appropriate medical screening examination . . . [and also any] necessary stabilizing treatment [required] for emergency medical conditions and labor."

In the case of In re Baby "K," the court described EMTALA as Congress' attempt to "provide an adequate first response to a medical crisis' for all patients." EMTALA created two basic requirements for hospitals subject to Medicare provider agreements. First, such a hospital with an emergency department must provide "appropriate medical screening" to conclude whether the patient who presents him or herself for

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52. Id.
53. Id. at 292-93.
54. Id.
55. Id.
56. Fell, supra note 50, at 608. Throughout the literature and cases the terms EMTALA and COBRA are used interchangeably to describe 42 U.S.C. § 1395dd (1995). In this Comment EMTALA will be used to avoid confusion.
57. Id. at n.9.
60. 16 F.3d 590, 590 (4th Cir. 1993).
61. Id. at 593.
62. Id.
63. In the medical profession the term "to present" means simply that a patient presents him or herself for treatment.
treatment at the emergency room is suffering from an emergency medical condition. To meet this requirement, a hospital must use the same screening procedures for everyone with the same symptoms or condition. Second, if an emergency condition is discovered, the hospital is required to treat the patient to “prevent material deterioration of the individual’s condition or provide for an appropriate transfer to another facility.”

Central to EMTALA is the fact that it “allows ‘any individual’ who presents him or herself at a hospital emergency room to invoke the protection of EMTALA when a hospital refuses to screen or stabilize the individual’s condition.” The United States Court of Appeals for the Fourth Circuit clarified this point in In re Baby “K.” In this case, a hospital argued that it should be allowed to discontinue periodic emergency treatment of an anencephalic infant. The hospital reasoned that EMTALA would not be violated by this denial of emergency care because Baby “K” was not an ‘individual’ under the meaning of EMTALA. The court rejected this argument, however, holding that EMTALA did apply to all individuals including anencephalic infants, and determined that the hospital had a duty under EMTALA to prevent a material deterioration in Baby “K”’s condition.

The interpretation of EMTALA by the court in In re Baby “K” illustrates that hospitals are required to provide access to emergency care to any and all individuals presenting at the emergency room. There is strong incentive for hospitals not to violate EMTALA. A hospital may be subject to civil penalties of up to $50,000 for each violation as well as potential exclusion from the Medicare program, “which could cost the

64. 16 F.3d at 590.
65. Id. at 594.
67. 16 F.3d 590 (4th Cir. 1993).
68. Anencephaly is a “congenital malformation in which a major portion of the brain, skull, and scalp are missing.” Id. at 592.
69. Id. at 594. The hospital reasoned that it should not have been obligated to provide respiratory support for Baby “K” when she came to the emergency room in distress because, in part, physicians considered such care medically and ethically inappropriate. Thus, EMTALA did not apply to this situation, despite the fact that failure to provide Baby “K” with emergency respiratory care would cause her condition to materially deteriorate. Id. at 594-95.
70. Id at 595-96. See also Epps, supra note 66, at 1209.
71. In re Baby “K,” 16 F.3d at 592.
EMTALA, however, has been judicially determined not to apply to MCOs, but rather only to hospitals. For example, in the case of Dearmas v. AV-Med, Inc., a patient who presented herself for treatment in a hospital emergency room was transferred to several other facilities by the order of her MCO. The patient sued the MCO claiming that the transfers caused delay which resulted in “irreversible neurological damages.” The court held, however, that the plaintiff did not have a cause of action under EMTALA because “the statute provides a private cause of action only against ‘hospitals.' This has resulted in situations where the hospital emergency department is forced by the federal government to provide service to an individual who is an MCO member, but the MCO, because it is not covered under EMTALA, is able to refuse payment to the hospital for services rendered.

Hospitals, thus have, found themselves in a “Catch 22” situation. MCOs put terrific pressure on hospital emergency departments to transfer or discharge their members. But the hospitals risk sanctions from the federal government if they comply with the MCO demands, and risk non-payment for MCO member care, if they do not comply.

It is argued that some MCOs have taken advantage of the fact that they are not subject to EMTALA, denying coverage and limiting member access to emergency care based on one of several theories. The MCO may refuse payment for member emergency room bills when the patient ultimately is determined not to have a medical emergency (retrospective denial), or when a member fails to get prior authorization for treatment at a hospital that is not a part of the MCO system (prospective denial).

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72. Loder & Clark, supra note 17, at B9.
74. Dearmas was the only case found dealing directly with the issue of MCOs not being subject to EMTALA, but rather only hospitals. EMTALA’s application to only hospitals also is found in the several cases holding that EMTALA only applies to hospitals and does not apply to physicians. See Richardson v. Southwest Miss. Regional Med. Ctr., 794 F. Supp. 198, 200 (S.D. Miss. 1992); Delaney v. Cade, 756 F. Supp. 1476, 1486-87 (D. Kan. 1991); Baber v. Hospital Corp. of America, 977 F.2d 872, 877 (4th Cir. 1992); Howe v. Hull, 873 F. Supp. 70, 71 (W.D. Ohio 1994).
75. Dearmas, 814 F. Supp. at 1103.
76. Id. at 1105.
77. Id.
78. Loder & Clark, supra note 17, at B11.
79. Id.
80. Id. at B9.
81. See Craig, supra note 2, at 136; Roukema, supra note 33; Baldassano, supra note 3, at 1545.
addition, MCOs are sometimes unwilling to authorize care for conditions that are not classified by the MCO as an emergency. The end result is that some MCOs have severely limited access to emergency medical care in their pursuit of keeping costs down.

IV. THE STATES ATTEMPT TO REGULATE THE ROLE OF MCOs IN EMERGENCY MEDICAL CARE

States have been forced to face the fact that the obligations put on hospitals to guarantee emergency medical care by EMTALA do not extend to MCOs. In addition, states have had to face concerns regarding MCOs discouraging their members' use of "911" emergency phone services. Several states have responded by promulgating their own laws regulating MCOs with regard to emergency medical service. The goals of these laws are to ensure that MCO members have adequate access to emergency medical care and that MCOs do not set up unreasonable roadblocks that shield them from the financial cost of this care.

For example, the state of Maryland has endeavored to stop retrospective denials of emergency care coverage by MCOs with the institution of a uniform definition of emergency that is based on a "prudent layperson" standard. This has required payment decisions to be determined by the symptoms of the patient, rather than on whether the MCO member finally is diagnosed to have an emergency medical condition. Virginia.

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82. See supra note 3 and accompanying text.
83. Baldassano, supra note 3, at 1545.
84. See supra notes 77-78 and accompanying text.
85. 911 emergency telephone systems are designed to reduce the response time for medical emergencies. A survey conducted by the Department of Surgery, University of Illinois, Chicago, showed that of the 16 major MCOs in the Chicago area, 15 of them (containing 99% of the area's total MCO-members) did not advise the use of a 911 number as the first response to a medical emergency. Rather, they advised their members to contact either the MCO office, or the patient's primary care physician first. In addition, only two MCOs (containing only seven percent of the area's total MCO-members) suggested in their brochures that the 911 emergency number be used. "These data suggest that... [MCO members] may not be adequately informed regarding proper use of 911 and the emergency medical services system." Hossfeld & Ryan, supra note 41, at 374-75. See also Phone-a-Nurse Cuts Down on ER Visits, HEALTH Bus., Dec. 3, 1993 available in LEXIS, Health Law File (illustrating a program used by Blue Cross/Blue Shield of Oregon specifically designed to have members call nurses in order to avoid alleged unnecessary member visits to emergency rooms).
86. See infra notes 88-100 and accompanying text (discussing examples of state laws attempting to regulate MCOs).
87. Id.
89. Id. at §19-701(f).
Arkansas, Illinois are other states that have adopted a definition of emergency premised on the "prudent layperson" standard.

The Maryland definition of "emergency services," based on the "prudent layperson" standard, is as follows:

"Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

The "prudent layperson" standard removes the ability of a MCO to develop its own interpretation of an emergency, and prevents the MCO from using its own definition to deny a member coverage for emergency medical service. The Illinois Emergency Medical Service statute, similar to the Maryland statute, provides that "'emergency' means a medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required." Arkansas also has sought to put an end to the MCO practice of delaying or denying emergency medical care for their members because the MCO-member failed to get the required prospective authorization for treatment.

California has one of the most detailed statutes governing MCOs regarding emergency medical service. For example, California requires that MCOs provide "24-hour access for enrollees and providers to obtain timely authorization for medically necessary care." Additionally, MCOs must pay hospitals for emergency medical services provided to MCO-members "until the care results in stabilization of the enrollee." California also prohibits MCOs from requiring prior authorization for

92. 1995 Ill. Laws 177.
94. 1995 Ill. Laws 177.
97. Id.
98. Id.
emergency medical service if federal or state law requires that "emergency services and care be provided without first questioning the patient's ability to pay."\textsuperscript{99} In fact, the only reason that an MCO is allowed to deny payment for a member's emergency medical service is if it is found that the provider never performed the services listed on the bill.\textsuperscript{100} This statute seems to be an attempt to deal directly with the failure of EMTALA to regulate MCOs with regard to emergency medical service.

V. THE STATES ENCOUNTER THE ROADBLOCK OF ERISA PREEMPTION

A. The Basics of ERISA Preemption

Despite the desire to regulate MCOs regarding emergency medical service, a number of states have found their efforts frustrated by preemption under the federal Employee Retirement Insurance Security Act ("ERISA").\textsuperscript{101} A discussion of the main points involving ERISA preemption will provide an understanding of the general problems that states have in trying to reform and regulate health care through state legislation. However, it is beyond the scope of this Comment to present an exhaustive analysis of ERISA preemption issues.\textsuperscript{102}

Preemption is based on the Supremacy Clause of the United States

\textsuperscript{99} Id.

\textsuperscript{100} Id.


Constitution. The doctrine of preemption requires that if any state law is in actual conflict with an act of Congress by express provision, by implication, or by a conflict between state and federal law, the federal law supersedes, or preempts, the state law. In fact, ERISA § 514(a) has in it a specific preemption clause. Simply put, ERISA preempts any state laws that "may now or hereafter relate to any employee benefit plan described in section 1003(a)."

The court in *Corcoran v. United Healthcare, Inc.* noted that "[t]he most obvious class of pre-empted state laws are those that are specifically designed to affect ERISA-governed employee benefit plans." An ERISA employee welfare benefit plan is defined as a plan established by an employer that provides its participants or beneficiaries "through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability."

1. The Courts Interpret ERISA Preemption Clause

In general, the rule is that "ERISA 'supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.'" The Supreme Court first interpreted the "relates to" language in *Shaw v. Delta Air Lines, Inc.* The Court in *Shaw* held that a law 'relates to' an employee benefit plan "if it has a connection with or reference to such a plan." This broad interpretation of ERISA preemption effectively preempted a state law that touched on an employee benefit plan, even though the statute was not designed to regulate specifically an employee benefit plan.

At one time it appeared that the expansion of ERISA preemption was without limit. This trend changed, however, when the Supreme Court

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103. U.S. Const. art. VI, § 2.
107. *Corcoran*, 965 F.2d at 1321.
108. *Id.* at 1329.
110. *Id.* (emphasis added).
113. *Id.*
reversed the United States Court of Appeals for the Second Circuit in *New York Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.* 114 In *Travelers*, the Supreme Court criticized the broad definition of "'relates to' in *Shaw,"" 115 rejecting the Second Circuit's finding of broad preemption. 116 *Travelers* appeared to adopt the more narrow interpretation of ERISA preemption, as had been in expressed in *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital.* 117

2. A Broad Interpretation of ERISA Preemption

Under the broad interpretation of the "relates to" clause, a variety of claims against MCOs based on state law are preempted by ERISA. In one case, for example, the court held that when a claim based on state law concerned the administration of MCOs (such as dealing with a benefit decision) ERISA preempts the state law. 118 In *Corcoran v. United HealthCare, Inc.*, 119 the United States Court of Appeals for the Fifth Circuit held that a Louisiana state law tort claim was preempted by ERISA because the claim involved "medical decisions incident to benefit determinations" made by an "independent professional medical review organization" 120 retained by the plaintiff-appellant's MCO. 121 The plaintiff-appellant in *Corcoran* argued that the appellee medical review organization was liable in tort for the wrongful death of their unborn child because of the "utilization review" the organization conducted. 122 While this medical review organization was not itself the administrator of the plaintiff-appellant's medical plan, the "claim related to her employee

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117. 995 F.2d 1179, 1192 (3d Cir. 1993). *United Wire* held that a "rule of law relates to an ERISA plan if it is specifically designed to affect employee benefits plans, if it singles out such plans for special treatment, or if the rights or restrictions it creates are predicated on the existence of such a plan." *Id.* The court further held that a state legal requirement does not "relate to" an ERISA-covered plan if it is "a statute of general applicability" that "does not single out ERISA plans for special treatment" and that "functions without regard to the existence of such plans." *Id.*
119. 965 F.2d 1321 (5th Cir. 1992).
120. *Id.* at 1324.
121. *Id.* at 1331.
122. *Id.* at 1323-24.
benefit plan because, but for the plan, . . . [it] would not have been involved in the case." 123 The utilization review caused the denial of certain medical care which the plaintiff-appellant claimed resulted in the death of the unborn child. 124 The court held that while the appellee did make medical decisions, it did so "in the context of making a determination about the availability of benefits under the plan." 125 Therefore, the plaintiff-appellee's claim was "pre-empted by ERISA." 126

An example of state law, designed to regulate MCO emergency medical service payment and access procedures, struck down based on the theory of ERISA preemption is found in Dearmas v. AV-Med, Inc. 127 In Dearmas, the plaintiff brought a tort action against an MCO, alleging that the MCO "failed to provide [the patient with] a medical screening examination, to stabilize treatment and transferred her in an unstable condition; all in violation of [Florida statute, section] 395.0142." 128 The Florida statute at issue in Dearmas was similar to the Federal EMTALA statute forbidding patient-dumping. 129 The Florida statute, like EMTALA, required hospitals to provide "appropriate medical screening" to evaluate a patient's condition to establish whether or not an emergency medical condition existed. If the patient suffered from an emergency medical condition, then the hospital was required to stabilize the patient before the patient could be transferred. 130 The court in Dearmas ruled, however, that ERISA preempted the Florida law under the theory that "the circumstances surrounding the transferring from one medical facility to another, in violation of section 395.0142 involved . . . [the MCO's] administration of the Plan." 131 The court determined that the plaintiff's claim "related to" the MCO's administration of the plan and thus was preempted by ERISA. 132 This shows how an EMTALA-like state law, specifically meant to apply to MCOs, was preempted by ERISA.

The lesson of Corcoran and Dearmas is that regardless of a state's best intentions to regulate MCOs in terms of emergency medical service, whenever MCO decisions regarding its participants come under ERISA

123. Conrad & Seiter, supra note 101, at 198.
125. Id. at 1331.
126. Id.
128. Id. at 1106.
129. Id. at 1108.
130. Id.
131. Id. at 1107.
132. Id.
and the law "relates to" the administration of the plan, the law is pre-empted by ERISA. For example, if a state law was intended to prohibit an MCO from denying or limiting coverage, the courts were "of one mind" that the claim was pre-empted by ERISA.133

3. The Scope of ERISA Preemption Narrows

The recent Supreme Court case of New York Conference of Blue Cross Plans v. Travelers Insurance Co.134 appears to limit the breadth of ERISA preemption. Rejecting the argument that ERISA preempted the state law, the Court upheld a state law requiring hospitals to impose a surcharge on all health care payers except Blue Cross/Blue Shield.135 The Court also took the opportunity to note that Congress, in creating ERISA, did not intend to "displace general health care regulation, which historically has been a matter of local concern."136 The Court rejected the notion that ERISA preempts all state laws affecting costs and charges that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services.137 Thus, a state may impose regulations on a plan that only indirectly affects the ERISA welfare benefit plan, at least in cases like Travelers which involve cost issues concerning surcharges required by the state. It may be that this decision reduces the ERISA preemption roadblock that has thwarted the states' attempts to regulate healthcare, especially emergency medical care, though this is by no means certain.138

B. An Exception to ERISA Preemption: The Savings Clause and the Deemer Clause

Even if a law is found to "relate to" an employee welfare benefit plan, it still may be saved from preemption if the law is intended to regulate insurance.139 Under the insurance savings clause, the states regain the

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133. Conrad & Seiter, supra note 101, at 198.
135. Id.
136. Id. at 1680.
137. Id. at 1679.
138. See Daly D.E. Temchine & Marcia S. Handler, Supreme Court Decision in Travelers Leaves Room for Managed Care Entities to Argue ERISA Preemption, 4 Health L. Rep. (BNA) 1199, 1200 (Aug. 3, 1995) (reading the Travelers decision as not limiting ERISA, pointing to the Court's warning that where a state law has "acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage . . . such a state law might indeed be pre-empted." 115 S.Ct. at 1683).
power to "enforce those state laws that 'regulate insurance' except as provided in the deemer clause. But under the deemer clause an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance." Thus, the savings clause and the deemer clause allow states to regulate plans that are insured, indirectly, by regulating the insurer and the insurer's contracts.

The Supreme Court interpreted the insurance clause in Metropolitan Life Insurance Co. v. Massachusetts. Here the Court held that "insured ERISA health plans were subject to State insurance law mandating specific benefit features, which in this case were mental health benefits."

A related issue is whether MCOs themselves are to be considered a form of insurance if the MCO provides service to an employee welfare benefit plan. It appears that there is some division among the jurisdictions in this regard. Some courts have construed MCO health plans, which are provided by employers to employees as part of a benefits package as ERISA employee welfare benefit plans. Under this theory, it is "commonly accepted" that MCOs are subject to ERISA where the MCO coverage is purchased by a private employer for its employees as part of a health benefits package. Other courts, however, have found MCOs to be insurers and thus exempt from ERISA preemption under the insurance savings clause.

C. Self-Funded Plans: The Achilles Heel of State Health Care Reform Efforts

One type of plan that definitely is subject to ERISA preemption, however, is the self-funded plan. The Supreme Court has determined that

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140. Id.
142. Michael S. Gordon, Managed Care, ERISA Pre-emption, and Health Reform-the Current Outlook, 3 Health Care Pol'y Rep. (BNA) 647, 648 (Apr. 17, 1995).
143. Conrad & Seiter, supra note 101, at 198. See also O'Reilly v. Culeers, 912 F.2d 1383 (11th Cir. 1990) (holding that HMOs are not insurers under the ERISA savings clause because they are both insurers and providers and in some instances not regulated by state insurance commissions).
144. Conrad & Seiter, supra note 101, at 198.
146. PATRICIA A. BUTLER, J.D., NAT'L GOVERNORS ASS'N, ROADBLOCK TO REFORM: ERISA IMPLICATIONS FOR STATE HEALTH CARE INITIATIVES 20 (1994).
self-funded health plans are not insurance, and thus not subject to state
regulation under ERISA's deemer clause.147 Since the Supreme Court
decided Metropolitan Life, many employers have changed from insured
ERISA health plans to self-funded health plans.148 This has meant that
many self-funded managed care programs are left protected by ERISA
preemption, and thus exempt from state regulation.149 The General Ac-
counting Office ("GAO") estimated that in 1993 forty-four million per-
sons were enrolled in self-funded ERISA health plans.150

VI. SOLUTIONS

A. Federal Action

Passage of a federal statute regulating emergency medical service is
one solution to the shortcomings of the current legal situation. The Ac-
cess to Emergency Medical Services Act of 1995151 ("AEMSA") was one
proposed piece of legislation that was introduced into the 104th Congress
by Congressman Ben Cardin and co-sponsored by Congresswoman
Marge Roukema. It failed to pass, but has been reintroduced into the
105th Congress with some changes, discussed below, which may increase
its chances of passage by Congress.

The AEMSA was intended to solve the problems associated with the
regulation of MCO emergency medical service coverage. Congressman
Cardin argued that a federal remedy is needed, in part, because states
cannot regulate self-insured health plans that come under ERISA, due to
the threat of preemption.152 The AEMSA, which would be federal law,
would not suffer from ERISA preemption.

One of the important features of the AEMSA was that it provided the

147. Id. See also American Med. Sec., Inc., 915 F. Supp. at 745 (citing FMC Corp., 498
U.S. at 61 (holding that the deemer clause exempts self-funded ERISA plans from state
laws)).
148. Metropolitan Life was decided in 1985. 471 U.S. at 724. The United States Gen-
eral Accounting Office estimated that "the percentage of plan participants enrolled in self-
funded health plans has increased from about 28 percent in 1986 to about 46 percent in
1993." United States General Accounting Office, Employer-Based Health
"GAO"].
149. Id. at 12. The GAO notes that large firms are where use of self-funding is most
prevalent. The GAO reports that "78 percent of firms with 1,000 or more employees and
89 percent of firms with 20,000 or more employees were self-funded in 1993." Id.
150. Id. at 9.
152. Baldassano, supra note 3, at 1546.
nation with a uniform definition of emergency. The AEMSA adopted the "prudent layperson" definition of emergency in Maryland, Virginia, Arkansas, and Illinois and incorporate it as the national, uniform definition. Additionally, the AEMSA dealt directly with the issue of MCO payment denials to hospital emergency departments for care provided to MCO members. It eliminated the situation where the hospital emergency department is required by federal law to provide screening and care to presenting patients, yet allowed MCOs to deny payment after their member had received emergency care, based on retrospective reviews. The AEMSA required that all health plans pay hospitals and physicians for federally required emergency medical service.

In addition to payment issues, the AEMSA also addressed the question of MCO restrictions on patient access to emergency medical service. The AEMSA prohibited the pre-authorization requirement for emergency services and the requirement that the MCO member must use a MCO network facility. In another effort to control gatekeeping procedures, the AEMSA mandated that MCOs provide twenty-four hour access and timely authorization (no more than thirty minutes) for MCO members requiring emergency care. Finally, the AEMSA promoted access to emergency medical service by assuring that MCOs not only encourage the use of the "911" emergency telephone system, but also barred MCOs from creating "barriers" to the system's appropriate use.

Changes to the AEMSA, reintroduced into the 105th Congress as the Access to Emergency Medical Services Act of 1997 ("AEMSA-97"),
include several important refinements. Perhaps the most important refinement is that the AEMSA-97 will implement the strategy of amending ERISA to include the AEMSA-97's provisions, a strategy that was used in the two health care reform bills that did pass the 104th Congress.\footnote{168} These are the Kennedy-Kassebaum Insurance Reform Bill,\footnote{169} and the Newborns' and Mothers' Health Protection Act of 1996.\footnote{170} AEMSA-97 also provides that there is no preemption of state law "as long as the state law does not prevent the application of federal law."\footnote{171} Additionally, AEMSA-97 permits health plans to create "reasonable cost-sharing differentials for emergency care" for times when a plan participant decides to utilize an emergency, rather than a nonemergency, setting or when an out-of-plan emergency setting is chosen over an in-plan setting.\footnote{172} The AEMSA-97 continues to prohibit a requirement of preauthorization before a patient may use emergency medical services.\footnote{173} Moreover, the AEMSA-97 continues to use the "prudent layperson" standard to define emergency and requires health plans to instruct their members on the "appropriate use of emergency medical services, including the use of the 911 system."\footnote{174}

The Original AEMSA received support from within the health care industry, including the American College of Emergency Physicians, the Emergency Nurses Association, and the American Association of Neurological Surgeons.\footnote{175} Supporters of the AEMSA-97 also include the American Medical Association,\footnote{176} and the American Hospital Association.\footnote{177} Concerns about the Act, however, have been voiced by some in the managed care industry.\footnote{178}

One concern of MCOs is the use of the "prudent layperson" definition

\footnote{168}{Id.}
\footnote{170}{42 U.S.C. § 300gg-4 (1996); 29 U.S.C. § 1185 (1996). These acts require that new mothers and their infants be allowed to stay in the hospital for at least 48 hours after delivery. \textit{Id}. The act pertains to "all health plans, including HMOs and self-funded plans." Caldwell, \textit{supra} note 15, at 48-54.}
\footnote{171}{Id.}
\footnote{172}{Id.}
\footnote{173}{Id.}
\footnote{174}{Id.}
\footnote{175}{Baldassano, \textit{supra} note 3, at 1546.}
\footnote{176}{\textsc{American Medical Association}, \textsc{Statement}, \textsc{AMA Applauds Introduction of "Access to Emergency Services Act"} (Feb. 25, 1997).}
\footnote{177}{\textsc{American Hospital Association}, \textsc{Statement on the Access to Emergency Medical Services Act of 1997} (Feb. 25, 1997).}
\footnote{178}{Lloyd, \textit{supra} note 35, at A1, A10.}
of emergency. MCOs are concerned that the courts might interpret the "prudent layperson" standard so broadly that MCOs never would be allowed to deny care. 179 It is feared that the statute would mandate payment for the slightest pain. 180 However, one major MCO, Kaiser Permanente, endorsed the prudent layperson standard. In August 1996, it issued a joint statement with the ACEP calling for federal standards for coverage of emergency medical services. 181 Kaiser Permanente has also announced its support for the AEMSA-97. 182

The MCO industry is concerned with curtailing unnecessary and inappropriate use of emergency medical service by MCO members. 183 This stems from the pressure that employers put on MCOs to lower inappropriate use of emergency services. 184 This is because emergency medical care is expensive, and its unpredictable, episodic nature is in direct conflict with the coordinated care that MCOs are in business to provide. 185 MCOs contend that to keep costs down they must be able to stop their members from using the hospital emergency room for trivial medical problems that could be handled better by a primary care physician. 186

179. For a good discussion of the opposing sides of the "prudent layperson" definition of emergency debate, see Clark, supra note 1, at 16-18. See also Baldassano, supra note 3, at 1546.

180. Sharn, supra note 6, at 1 (expressing concerns of Roger Taylor, Chief Medical officer at Cypress, California based Pacificare Health Systems Inc., a major California MCO).


183. See Pear, supra note 6, at 1, 22.

184. Id.

185. Id.

186. Sharn, supra note 6, at 1 ("[I]nsurers say that to hold down ever-spiraling health costs they must stop people from using the hospital for problems, many bordering on the trivial, that could be treated much more cheaply in a doctor's office."). See Baldassano, supra note 3, at 1546. Jonna Kurucz, director of health care policy for The Prudential Insurance Company of America stated that "[e]mergency rooms are often used as a substitute for a person's primary care physician." Id. See also Lloyd, supra note 35, at A1, A10 (One example of such a trivial problem was given by Camille Dobson, deputy director of the Maryland Association of Health Maintenance Organizations. Dobson states that "[w]e have an example that a patient presented (himself in the emergency room) because . . . [the patient's] hair was falling out simply due to balding.").
Thus, anything that the AEMSA does to restrict MCOs from managing their members’ care is something that MCOs naturally would oppose.

B. Selective State Exemption from ERISA Preemption

Another solution to the problems concerning the regulation of MCOs and emergency medical care is for Congress to exempt individual states from ERISA. Exemption from ERISA on a state-by-state basis would remove a major obstacle to health care reform for those states enacting comprehensive statutory reform measures. Without such an exception, such programs are deemed to be preempted by ERISA because they “relate to” employee benefit plans. Currently, the only state specifically exempted from ERISA preemption is Hawaii, which implemented a law requiring most employers to provide employees with health insurance. The possibility of general state-specific exemption from ERISA, however, seems unlikely. In 1994, a bill was introduced into the Senate that would have permitted state-specific ERISA exemptions. This bill went nowhere, however, in large part because business is opposed to health care regulations that vary widely from one state to another. After this defeat, there is still Congressional interest in creating state-specific exemptions, although there is nothing on the horizon to suggest Congress will adopt state-specific ERISA preemption waivers.

C. The MCO Solution

The attitude of some in the managed care industry concerning the issue of emergency medical service is that no additional regulation is needed. It has been suggested that problems concerning MCOs and emergency medical service are not industry-wide, but instead are a minimal problem caused by a few MCOs. For example, while there are

189. See Blankenau, supra note 187, at 38. In 1994, a bill was introduced into the Senate by Senator George J. Mitchell, Senator Bob Graham, and Senator Mark O. Hatfield to allow state-specific exemption from ERISA. Id.
190. Id. at 40.
191. See id.
192. Baldassano, supra note 3, at 1546.
193. Sharn, supra note 6, at 1.
some MCOs that deny less than one percent of MCO-member emergency medical service claims because they were either not authorized or not urgent, there are other plans which deny fifteen percent or more of all claims.\textsuperscript{194} The refusal of claims may vary widely, with some MCOs denying coverage two to three times the number of claims other MCOs at the same hospital reject.\textsuperscript{195}

It has been argued that market forces will solve whatever problems exist in regard to MCOs and emergency medical care. Simply put, if individuals choose not to join the offending MCOs, this market decision on the part of the consumer will cost the offending MCOs money, and force them to change their ways.\textsuperscript{196} One response to this argument, however, is that today many individuals do not have a choice of health care providers because this decision is made by their employers.\textsuperscript{197} Given the constant pressure in business to reduce the bottom line, many employers might be willing to sign on with a MCO if it is less expensive, despite the fact that the MCO limits payment for, and patient access to, emergency medical care.

The thrust of the MCOs' argument might be summed up as follows. Problems with MCO payment for and coverage of emergency medical service are isolated and are not widespread throughout the industry.\textsuperscript{198} The limited problems that do exist are a result of growing pains that result from the transition from a fee-for-service health system to a managed care health system.\textsuperscript{199} It is the free market, not government regulation, that will provide the best solution because the free-market will force out those MCOs that are not meeting their members' emergency health care needs, making the system more efficient.\textsuperscript{200} Government reform, such as the Access to Emergency Medical Service Act, would just make the health care system more expensive by forcing MCOs to pay for unneces-

\textsuperscript{194} Id.
\textsuperscript{195} Id. (based on an analysis of claims handled by Emergency Physicians Billing Service in Oklahoma City).
\textsuperscript{196} See Baldassano, supra note 3, at 1546 (industry spokesman suggesting that ultimately, "employers and patients will demand access to emergency services").
\textsuperscript{197} One indication of the number of Americans that get their insurance through their employers is the GAO's estimate that 114 million persons, approximately 44% of the United States' population, receive medical coverage through ERISA health plans. GAO, supra note 148, at 2.
\textsuperscript{198} See Baldassano, supra note 3, at 1546.
\textsuperscript{199} Id. at 1548.
\textsuperscript{200} See id. at 1546.
sary emergency medical service.\textsuperscript{201}

\textbf{D. Maintain the Status Quo}

One final possibility is to do nothing on the federal level in terms of national regulations, or state-specific ERISA exemptions. Rather, the states might continue to pass reform legislation and look to the Supreme Court's ruling in \textit{New York Conference of Blue Cross Plans v. Travelers Insurance}\textsuperscript{202} to save their statutes from ERISA preemption. \textit{Travelers} upheld a state law that required hospitals to collect surcharges from all insurers other than Blue Cross/Blue Shield\textsuperscript{203}. It still is unclear, however, how far reaching this decision will be and whether it will save other types of state health care regulation from ERISA preemption\textsuperscript{204}.

\textbf{VII. Conclusion}

The current situation regarding federal and state regulation of MCO coverage of emergency medical service is unstable. The interaction of state and federal laws has created an environment that has allowed some players in the managed care industry to utilize abusive practices through which they avoid paying for, and hamper member access to, emergency medical service. It seems doubtful that the present system in which hospitals are required by federal law to provide emergency medical care to MCO members under EMTALA, while payment from MCOs is uncertain, will last indefinitely\textsuperscript{205}. Some critics of managed care warn that the current legal situation cannot last because if MCOs are too successful in avoiding payments to hospital emergency departments, some hospitals will be forced to close their emergency departments and emergency care may not be as widely available, especially to the poor\textsuperscript{206}. It is apparent that because EMTALA was created before the advent of managed care, and because it has been held to apply only to hospitals and not to MCOs,

\textsuperscript{201} See id. (presenting the argument that legislation such as the AEMSA would eliminate incentives to use emergency medical service in a cost-effective way).

\textsuperscript{202} 115 S.Ct. 1671 (1995).

\textsuperscript{203} \textit{Travelers}, 115 S.Ct. at 1683.

\textsuperscript{204} See supra notes 134-38 and accompanying text (discussing the \textit{Travelers} decision and its effect on ERISA preemption of state health care law).

\textsuperscript{205} Loder & Clark, supra note 17, at B9.

\textsuperscript{206} See Clark, supra note 1, at 19; Williams, supra note 13, at 642-46 (suggesting that the cost of emergency room visits for non-urgent care is not, in fact, that great and that the potential savings from diverting all nonurgent visits to private doctor's offices may be much less than is widely believed).
it is inadequate for today’s health care environment, must be supple-
mented or replaced.
While the managed care industry might prefer the free market to solve
what they consider to be isolated problems with emergency medical care,
it seems unlikely that will happen. Even if AEMSA-97 never becomes
law, it appears that many states are eager to find other ways to regulate
MCOs and emergency medical care. It may be that with the Supreme
Court’s Travelers decision, ERISA may be less likely to preempt state
laws regulating health care.
In the final analysis, a federal statute such as the Access to Emergency
Medical Service Act may be the best solution to the complicated legal
issues surrounding the regulation of payment for and access to, MCO
member emergency medical care. AEMSA-97 addresses financial and
access concerns by providing a uniform solution applicable to all the
states. Employers, MCOs, hospitals, and individuals could, under the
AEMSA-97, depend on a national regulatory framework for MCOs and
emergency medical care, rather than be forced to deal with the patchwork
of state laws that would likely evolve if no federal legislation is passed.
Importantly, although AEMSA-97 does provide national uniformity, it
also gives states flexibility to enact their own legislation, so long as it
“does not prevent the application of federal law.” Thus, AEMSA-97
would ensure a minimum standard of emergency medical care for all
MCO members, including those who are in self-funded plans.

Christopher J. Young

207. Cardin Announcement, supra note 167.