The ER Crisis and Immigration

BY EDWIN S. RUBENSTEIN

You're having shortness of breath. Feels like early stages of a heart attack. Luckily, you are across the street from a hospital. You walk in, but the ER is full of people who appear to have been there for a long period of time. There is no physician visible. A nurse calls an ambulance to take you to another ER. But instead of going to the closest facility, the EMS medics take you to a third hospital on the other side of town, where doctors and nurses are waiting to administer lifesaving treatment. You are clutching your chest and sweating profusely, but the driver explains that the nearest hospital is "on diversion" — temporarily closed to ambulances because of overcrowding in the ER.

You are lucky. You survive. Others do not. Consider the tragic case of a 58-year-old man in Dallas. He had been suffering severe stomach pains and had gone to the Parkland Memorial Hospital ER waiting room. He waited 19 hours for medical attention, but it never came. A heart attack ended his long wait.[1]

ER death rates in areas where hospitals are on diversion are significantly higher than in places where local hospitals are ambulance ready.[2] For heart attack victims, the diversion/non-diversion death rate difference is greater than those associated with different medical treatments.

Everyone has a right to be treated in an ER for life-threatening emergencies. But most ER patients are admitted for mundane, non-critical ailments, such as colds, sore throats, and headaches. And hospitals divert ambulances elsewhere not because they are busy treating other critically ill individuals, but because they simply cannot afford to hire enough medical personnel to keep their ERs open 24/7.

***Edwin S. Rubenstein**, a regular contributor to* The Social Contract*, is president of ESR Research, economic consultants. As a journalist, Mr. Rubenstein was a contributing editor at* Forbes *and economics editor at* National Review*, where his "Right Data" column was featured for more than a decade.*

How did our Emergency Rooms reach this critical condition?

ERs for All

The mission statement of U.S. emergency rooms was written in Washington more then a quarter century ago. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires ERs to screen, treat, and stabilize patients whether or not they are insured, "documented," or able to pay. Hospital ERs must have doctors available to them at all times from every department and specialty covered by the hospital. They must have translators.

Signed by Ronald Reagan in 1986, EMTALA defines an *"emergency"* as any complaint brought to the ER, from hangovers to hangnails, from gunshot wounds to AIDS. Any patient requesting "emergency" care must be treated until ready for discharge, or stabilized for transfer. A woman in labor must remain to deliver her child.

Lack of insurance leads many immigrants to use hospital emergency departments — the most expensive source of health care — as their primary care provider. This leads to overcrowded conditions for citizens who seek emergency care. Nationwide, half of hospital admissions came through emergency departments in 2006, up from 36 percent in 1996.[3]

The hottest ER diagnosis, according to the late medical lawyer Madeleine Cosman, is *"permanent disability"* — a vaguely defined condition that covers mental, social, and personality disorders. Drug addiction and alcoholism are among the most common "disabilities."[4] A disability diagnosis makes patients eligible for Supplemental Security Income (SSI), a federally funded cash transfer payment. Once an individual qualifies for SSI, they automatically become eligible for Medicaid, Food Stamps, and housing vouchers. So when some illegals enter the ER, they receive medical care plus what amounts to a long-term financial annuity.

Nineteen eighty-six is also the year that Ronald Reagan signed an immigration amnesty: The Immigration Reform and Control Act (IRCA.) The timing is no

coincidence. While IRCA increased the number of illegal alien workers available to U.S. businesses, EMTALA shifted their medical insurance costs to non-business payers. Taken together, the two laws constitute a powerful subsidy to illegal alien employers — a subsidy paid for by native workers and taxpayers.

Whether people know it or not, whether people appreciate it or not, access to emergency room care became a right in this country in 1986. But the law that did that never addressed the question of whose responsibility it was to deal with the cost.

EMTALA is an unfunded federal mandate imposed on U.S. healthcare providers. A very expensive mandate: annual unreimbursed medical expenses for the uninsured are estimated at between $9 billion and $11 billion. Some of these costs are absorbed by county welfare departments or hospitals obligated to provide treatment; some of them are shifted to privately insured patients.

The average added cost an insured individual pays to cover treatment of the uninsured has been put at $370 a year, while for a family it is an additional $1,000 a year.[5]

The federal government imposes stiff fines on any physician or hospital refusing to treat an ER patient, even when the patient has been screened and declared a non-emergency case by ER personnel. Amazingly, ER patients are given the private right to sue hospitals for any "financial loss" stemming from EMTALA violations.[6]

The inescapable inference: illegal aliens can sue U.S. doctors and hospitals for alleged EMTALA violations.

Even Mexicans in Mexico regard EMTALA as their entitlement: Ambulances drive from Mexico to U.S. border hospitals, drop off indigent patients, and leave secure in the knowledge that their fares will be admitted. The drivers apparently know that EMTALA requires hospitals to accept anyone who is within 250 yards of a hospital — no matter how they got there.

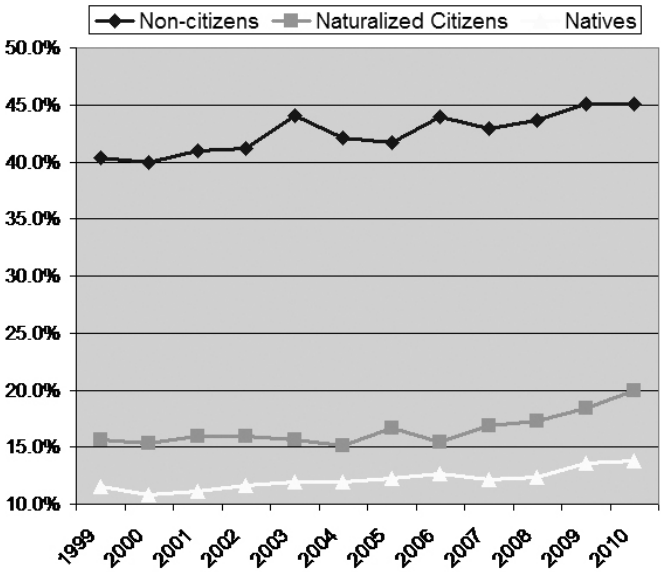
EMTALA is not just for immigrants, of course. Any uninsured person — native or foreign-born — receives the same ER privileges. But foreign-born are far more likely to be uninsured (see graphic next column).

Approximately 45 percent of non-citizens — a group that includes illegal aliens — were uninsured in 2010. That is twice the uninsurance rate of naturalized citizens (20 percent) and 3.2 times the rate of natives (13 percent.)

In 2010 more than one in four uninsured U.S. residents was an immigrant; 32 percent of uninsured residents are immigrants or their U.S.-born children. And nearly one-half (48 percent) of immigrants and their children are uninsured or depend on Medicaid.

Measuring uninsurance rates of illegal aliens is problematic. They move frequently, fear detection, and are difficult to contact. In many places sanctuary laws prohibit hospitals from asking patients their citizenship status.

Percent of people without health insurance, 1999-2010
(Census Bureau data)



We uncovered one good source — a 1996 survey of undocumented aliens who voluntarily admitted their status upon registering for ER care. The study found: *"Undocumented Hispanics had a significantly higher rate of unfunded visits than both Hispanic and non-Hispanic legal residents (64.5 percent versus 32.1 percent and 30.4 percent, respectively.)"*[7]

Hispanic illegals in the ER studied were uninsured at more than twice the rate of legal Hispanics and non-Hispanics.

Keep in mind that about one-third of the illegals seen in this ER were insured. They had access to conventional non-ER care. Apparently they use the ER solely to avoid having to provide proof of citizenship. ERs have become safe houses for undocumented aliens.

More recent data confirm the fact that Hispanics are inundating ERs at a far greater pace than other ethnic groups (see table next page).

Annual ER visits by Hispanics increased 63 percent between 2001 and 2008. This increase is more than twice the increase that would be expected from Hispanic population growth during this period — a 27 percent increase.

From 2001 to 2008, Hispanic ER visits grew 15

times faster than those of non-Hispanic whites, and more than twice as fast as those of non-Hispanic blacks.

Lack of health insurance and/or a desire to remain undetected drives immigrants to use hospital ERs — the most expensive source of health care — as their primary care provider. *"Nobody is going to turn these folks down, we agree with that,"* said former Arizona Senate President Russell Pearce, who was also the primary sponsor of the state's immigration law. "But I get calls from doctors and nurses every day that work in the emergency room, talking about the abuse, the millions of dollars spent for folks who come in for pregnancy tests, sniffles — they use emergency room services as their primary care," he says. *"When do we stand up for the taxpayers?"*[8]

ER usage by race and ethnicity, 2001-2008

	2001	2008	% increase
	ER visits (millions)		
Total	107.5	123.8	15%
Non-Hispanic white	72.5	75.6	4%
Non Hispanic black	21.4	27.1	27%
Hispanic	10.7	17.3	63%
Other	3.0	3.7	23%

Data source: Stephen Pitts, et al. "National Trends in Emergency Department Occupancy, 2001 to 2008," Annals of Emergency Medicine, 2012. Appendix E1. (in press.)

Unintended Consequences

About 127 million Americans — or more than one in three Americans — visit hospital emergency rooms each year. The U.S. Centers for Disease Control and Prevention report a 44 percent increase in patient visits to ERs in the period 1991 to 2010. Over the same period, however, the number of hospital ERs fell from 5,108 to 4,564 — a decline of 11 percent:

The two trends — increased patient demand and decreased ER supply — have degraded the quality of ER care, forced some of America's finest emergency medical facilities to close, and bankrupted entire hospital systems.

Technically, hospitals have the option of not treating uninsured patients in their ERs. But those that choose this option are banned from billing the federal Medicare program for any services. Opting out of Medicare is unthinkable, so there is really no choice at all. Hospitals have to pass on the unreimbursed ER costs to people who have the ability to pay. Even insured patients do not pay the full costs of ER care, so closing the ER is often the only way out.

When a hospital ER closes it does not solve the problem. All the non-paying patients it formerly had to take care of have to drive farther to hospitals in more affluent areas. This can result in cascading failure, where the increased burden from one hospital shutting down creates an unsustainable burden on other nearby hospitals, ultimately causing a chain of hospital closures.

Between 1990 and 2008 more than 70 Emergency Rooms in California closed. Los Angeles saw a 26 percent reduction in ERs serving its population between 1993 and 2003. Nationally, almost one in ten hospitals was in diversion status in 2003. In LA County one of every four ambulances was on diversion that year.

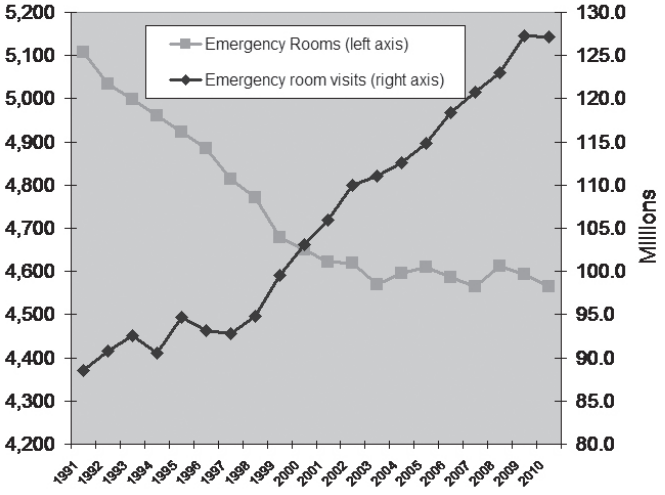
"This rapid escalation in losses has created an enormous burden on the remaining Emergency Departments," reported the California Medical Association. *"The drain on the system has led to longer waits for treatment, and left entire communities without a local emergency facility. Increasing patient volume and a decline in the number of emergency rooms has made multiple hour waits for emergency care the norm."*[9]

The average time that hospital emergency room patients wait before seeing a physician has been rising steadily, from 38 minutes in 1997, to 47 minutes in 2004, to 56 minutes in 2006, according to federal statistics.[10]

Seeing a doctor is just the first step in a process that takes hours, on average, until patients are discharged. In 2004 average total wait times for ER patients was 3.3 hours, according to the CDC. Nearly 400,000 patients had to wait for at least 24 hours before being discharged from the ER.

The average wait in a California Emergency Room is four hours and growing.[11]

Emergency Room Emergency: Supply down; Demand Up,1991-2010
(Data: American Hospital Association)



As California goes, so goes the nation. For decades the state has been "exporting" its immigrants to other states. Over half of California's 430 hospitals have cut back on treatment services or are planning to do so. This includes the closing of acute care facilities and psychiatric units as well as emergency rooms.[12]

Since the early 1990's the Los Angeles County Department of Health Services has been on the verge of collapse several times, saved only by federal bailouts. Today, with the state facing a $16 billion budget deficit, illegal aliens in LA cost taxpayers over $1 billion a year — $400 million of which comes from unreimbursed health care provided to illegal aliens.[13]

Immigrants are estimated to account for 60 percent of LA County's uninsured population. ERs are overcrowded and hospital beds are at a premium. There are only 1.9 hospital beds for every 1,000 residents in California, and that forces some patients to wait up to two years for routine gall bladder surgery. When hospitals shut emergency rooms, or cut back on other services to free up resources needed by immigrants, this affects the quality of care available for all.

EMTALA was supposed to make ERs more accessible to the uninsured. It didn't work out that way:

> *Not only did this unfunded mandate contribute to the closure of numerous emergency departments and trauma centers, it also created a perverse incentive for hospitals to tolerate emergency department crowding and divert ambulances while continuing to accept elective admissions. Rather than improving access to emergency care, EMTALA diminished it.*[14]

Talk about unintended consequences!

The push back

As the financial implications of EMTALA became evident, several states sued Washington for reimbursement. In 1994 Arizona, Florida, and California brought actions. Arizona's brief noted: *"The federal government's failure to honor the Constitution's express guarantee to protect Arizona's borders has forced Arizona to incur millions of dollars in avoidable costs."* Florida noted that its costs were due to *"the national government's massive and persistent failure to enforce the immigration laws."*[15]

Federal lawmakers acknowledged this burden, but their responses were laughable:

> The Illegal Immigrant Reform and Immigrant Responsibility Act of 1996 approved reimbursement for ER care as well as ambulance service provided to illegal aliens. Neither of those sections of this law was funded.
>
> In 1997, Congress approved $25 million a year for emergency health services for immigrants in the 12 states with the highest number of illegal aliens.
>
> The Medicare Modernization Act of 2003 provided a mere $250 million per year to reimburse hospitals for the costs of treating illegal aliens in emergency situations — a fraction of the total costs.[16]

California's Proposition 187, passed in 1994, stated: *"Publicly funded health care facilities must deny care, except in medical emergencies, to people who can not prove U.S. citizenship or legal residency status."* State courts ruled that this provision conflicted with existing state law. Subsequently, federal courts found that Prop.187 pre-empted federal law.

In 2010 Arizona passed several laws aimed at cracking down on illegal immigration. One of them required hospital personnel to report illegal immigrants to federal officials. The first law of its kind in the country, SB1405 states:

> Before a hospital admits a person for nonemergency care, a hospital admissions officer must confirm that the person is a citizen of the United States, a legal resident of the United States or lawfully present in the United States. The admissions officer may use any method prescribed to verify citizenship or legal status. If the admissions officer determines that the person does not meet the requirements of subsection a of this section, the admissions officer must contact the local federal immigration office. If the hospital provides emergency medical care pursuant to federal requirements to a person who does not meet the requirements of subsection a [i.e. fulfil the requirements of legal citizenship] of this section, on successful treatment of the patient, the admissions officer must contact the local federal immigration office.[17]

By the end of 2011 five other states passed broad bills modeled off of Arizona's law: Utah, Indiana, Georgia, Alabama, and South Carolina. In June 2012, however, the Supreme Court effectively overturned SB1405, ruling that Arizona could not pre-empt EMTALA — or

any other federal law granting services to illegal immigrants.

Hospitals are desperate. Some have taken matters into their own hands. In the past several years many have chartered air ambulances to fly sick immigrants to their home country (e.g., Mexico, Honduras, or Guatemala.) This "patient dumping" occurs with the tacit approval, but without the active involvement, of U.S. immigration authorities.[18]

Equally repugnant are the "birth packages" U.S. hospitals offer to wealthy foreign women. Pregnant Mexican women can schedule a cesarean section, enter the U.S. a few weeks before their due date, and be whisked to the Tucson Medical Center via TMC's "Super Shuttle" when it's time to deliver.

Birth package prices range from $2,300 to $4,600 — well below the prices charged to deliver children born to native-born women with health insurance. Who covers the difference? U.S. taxpayers, of course. The Mexican child is automatically a U.S. citizen whose hospital expenses can be funded, in part or in whole, by Medicaid.

The resulting profit helps defray costs of caring for destitute illegals in the ER.

A fully funded EMTALA would undoubtedly increase the number of ERs, reduce patient dumping, and curb citizenship obtained via the birthing room. But increased ER accessibility could also trigger an upsurge in illegal immigration, undoing many of these benefits.

Fix the ER crisis? Fix the border first. ■

Endnotes

1. http://www.safetyissues.com/site/health/long_wait_times_causing_er_deaths.html

2. Dr. Jesse Pines, "The Diverted Ambulance: How ER crowding kills," *Time*, June 27, 2011. http://www.time.com/time/health/article/0,8599,2079935,00.html

3. http://www.msnbc.msn.com/id/26056315/ns/health-health_care/t/average-er-waiting-time-nears-hour/

4. Madeleine Pelzer Cosman, "Illegal Aliens and American Medicine," *Journal of American Physicians and Surgeons,* Spring 2005.

5. FAIR, *The Sinking Lifeboat*, 2009.

6. Thomas Gustafson, Testimony, July 26, 2006. http://www.hhs.gov/asl/testify/t060726c.html

7. Dr. Theodore C. Chan, et al., "Survey of Illegal Immigrants Seen in an Emergency Department," *Western Journal of Medicine*, March 1996.

8. Daniel Sayani, "Illegal Aliens Overrun Arizona's Emergency Rooms," *The New American*, February 24, 2011.

9. California Medical Association, "A System in Crisis: ER Losses Mount," February 26, 2003.

10. http://www.msnbc.msn.com/id/26056315/ns/health-health_care/t/average-er-waiting-time-nears-hour/

11. "Deep Cuts Threaten to Reshape California," *The New York Times*, May 31, 2009.

12. "A report on California Hospitals in the Economy," CHA Special Report, California Hospital Report, January 2009.

13. FAIR, op. cit.

14. Arthur L. Kellermann, "Crisis in the Emergency Department," *New England Journal of Medicine,* September 28, 2006. http://www.nejm.org/doi/full/10.1056/NEJMp068194

15. FAIR, op. cit.

16. Ibid.

17. http://www.thenewamerican.com/usnews/immigration/item/2070-illegal-immigrants-overrun-arizonas-emergency-rooms

18. Jennifer M. Smith. "Screen, Stabilize, and Ship," *Houston Journal of Health Law and Policy*, 2010.