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Overview of the Emergency Medical Treatment and Active Labor Act (EMTALA) and Emergency Abortion Services

The Emergency Medical Treatment and Active Labor Act (EMTALA, largely codified in Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd) is a federal law that generally compels Medicare-participating hospitals to provide emergency care to any individual, irrespective of an individual's ability to pay. Enacted in 1986 amid reports of hospital emergency rooms refusing to treat poor or uninsured patients, the Act requires hospitals, as a condition of federal Medicare funding, to provide services to any individual presenting at an emergency department or face potential enforcement action.

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, questions have arisen about EMTALA and its relationship to state law, particularly in the context of emergency abortion services. This In Focus outlines EMTALA's central requirements and enforcement mechanisms; highlights the Act's preemptive scope and recent issues related to emergency abortion; and concludes with considerations for the 118th Congress.

Core Requirements: Screening, Stabilization, and Transfer

EMTALA has three main components. First, hospitals with an emergency department (including critical access hospitals and, effective January 1, 2023, rural emergency hospitals) must screen patients. Specifically, if an individual comes to the hospital's emergency department with a request for examination or treatment, hospitals must provide an "appropriate" medical screening examination by qualified medical personnel within the capability of its emergency department. The goal of this screening is to determine if an "emergency medical condition" exists. The Act does not expressly address the scope of the required examination or what constitutes "appropriate" screening. However, agency guidelines and several lower court decisions indicate that hospitals must follow the same screening procedures for all individuals presenting at the emergency department with the same signs and symptoms, regardless of an individual's payment status or other factors.

Second, if a hospital determines that an individual has an emergency medical condition, the hospital must either provide further medical examination and treatment to stabilize the patient using available staff or facilities, or transfer the patient to a different medical facility with more specialized capabilities. As defined in federal regulations, required stabilization involves treatment for an emergency medical condition "as may be necessary to assure, within reasonable medical probability, that no material deterioration . . . is likely to result from or occur during the

transfer . . . from a facility." Accordingly, for EMTALA purposes, stabilization generally depends on whether a patient's emergency condition would decline because of a facility transfer; a patient may be stabilized even if the patient's medical condition remains unresolved or the patient requires further medical treatment. EMTALA guidance offers an illustrative example:

[A]n individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. The physician completes a medical screening examination and diagnoses the individual as having an asthma attack that is an emergency medical condition. Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario, the [emergency medical condition] was resolved and the hospital's EMTALA obligation is therefore ended, but the underlying medical condition of asthma still exists.

Third, EMTALA restricts hospitals from transferring unstable patients unless the transfer is "appropriate" and meets certain conditions. Among these conditions, a transfer may occur if the hospital informs the patient of its EMTALA obligations and the risks of transfer, and the patient makes a written request for the transfer to another medical facility.

Notably, courts have generally concluded that EMTALA's core requirements are distinct from state medical malpractice requirements. While the Act requires hospitals to furnish medical services to patients, the statute does not impose professional standards of care or liability on hospitals or physicians that provide poor-quality care to patients. In other words, hospitals and physicians that fail to employ the proper procedures to screen or stabilize patients may violate EMTALA, while health care providers that, for instance, negligently misdiagnose a patient may violate state medical malpractice laws but not violate EMTALA.

"Emergency Medical Condition"

As noted, EMTALA obligations to treat a patient depend upon whether a patient has an "emergency medical condition." Under the Act, this condition is one in which an individual exhibits "acute symptoms . . . such that the absence of immediate medical attention could reasonably be expected to jeopardize an individual's health or result in serious impairment to bodily functions or dysfunction to bodily organs or parts." Pursuant to the Act and accompanying regulations, elements of an emergency

medical condition may include severe pain, psychiatric disturbances, or substance abuse symptoms. With respect to pregnant women, an emergency medical condition includes one that endangers the health of the woman or her unborn child.

Enforcement

Federal enforcement of EMTALA is a complaint-driven process that typically begins after the Centers for Medicare and Medicaid Services (CMS) receives information about a potential violation. Following receipt of a complaint, CMS may authorize an investigation to determine whether a violation occurred. When violations are identified, EMTALA guidance specifies that hospitals may adopt corrective action plans to address the deficiencies.

In certain instances in which a hospital or physician negligently violates EMTALA requirements, the Department of Health and Human Services (HHS) Office of Inspector General may impose civil monetary penalties of up to \$119,942 (as adjusted for inflation) for each violation. (Smaller penalty amounts apply to hospitals with fewer than 100 beds.) Hospitals and physicians that commit repeated or “gross and flagrant” violations of the Act may be excluded from participation in Medicare and other federally funded health care programs.

Aggrieved individuals and medical facilities may also sue a hospital for damages and other relief to address EMTALA violations. However, the Act does not explicitly provide a similar cause of action against physicians who commit such violations. Some courts have also recognized that injured third parties (e.g., a deceased patient’s heirs) may bring EMTALA suits against offending hospitals.

Preemption and Emergency Abortion Services

EMTALA expressly indicates that the Act’s requirements do *not* preempt state or local requirements except for those that directly conflict with the federal law. This provision has received considerable attention following the Supreme Court’s decision in *Dobbs*. In *Dobbs*, the Supreme Court concluded that the U.S. Constitution does not confer a right to an abortion. After the decision, several states passed measures to curtail access to abortion, including bans on abortion in particular circumstances.

Questions have arisen about the interplay between a health care provider’s duty to provide emergency abortion services under EMTALA and state restrictions that limit a health care provider’s ability to provide abortion care. After *Dobbs*, HHS issued guidance indicating that under EMTALA, if a physician believes that a pregnant patient

presenting at an emergency department is experiencing a condition that is likely or certain to become emergent, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. Examples of relevant conditions may include “ectopic pregnancy, complications of pregnancy loss, or emergency hypertensive disorders, such as preeclampsia with severe features.”

In July 2022, the State of Texas, in *Texas v. Becerra*, sued to block enforcement of the guidance while HHS, in *United States v. Idaho*, sued the State of Idaho to block enforcement of its abortion ban to the extent it conflicts with EMTALA. The two district courts reached conflicting conclusions: while the Texas court enjoined the guidance in the state, the Idaho court barred enforcement of Idaho’s abortion restriction to the extent it prohibits providers from providing emergency abortion services in circumstances required by EMTALA. The legal challenges are ongoing. (For a detailed discussion of the litigation, see CRS Legal Sidebars CRS Legal Sidebar LSB10850, *EMTALA Emergency Abortion Care Litigation: Overview and Initial Observations (Part I of II)* and CRS Legal Sidebar LSB10851, *EMTALA Emergency Abortion Care Litigation: Overview and Initial Observations (Part II of II)*, both by Wen W. Shen)

Considerations for the 118th Congress

As described by one of the Act’s sponsors, EMTALA tasks Medicare-participating hospitals with providing “an adequate first response to a medical crisis” for all patients. The Act creates a statutory duty to provide medical care in instances where such a duty may not otherwise exist. EMTALA, however, is not an express directive to provide uncompensated care; hospitals may still bill for the services provided.

Health care access, particularly for indigent patients, is an issue of perennial interest to Members of Congress. EMTALA may be examined should Congress consider legislation affecting emergency medical care. Congress may also chose to address how the Act intersects with state law in the context of emergency abortion services. Such legislation could clarify EMTALA’s preemptive reach and the precise circumstances under which hospitals must provide these services. Legislation on this issue could affect the outcome of the *Texas* and *Idaho* litigation.

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