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IN FOCUS

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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 treat any individual presenting at an emergency department or face potential enforcement action.

Following the Supreme Court's 2022 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 litigation related to emergency abortion services, and concludes with selected legal considerations for the 119th Congress.

Core Requirements: Screening, Stabilization, and Transfer

EMTALA has three main components. First, hospitals with an emergency department 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 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.

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.

In examining EMTALA, courts have generally concluded that the Act'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

EMTALA enforcement is largely 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 July 2026, CMS issued a proposed rule that would authorize hospital-accrediting organizations to assess compliance with certain administrative requirements of EMTALA (such as a requirement to post signage regarding patient rights under the Act) as part of routine accreditation surveys. In

the preamble to the proposed rule, CMS expressed that these changes may "enhance sustained compliance" with the Act.

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 $136,886 (in 2026, 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. The Act does not explicitly provide a similar cause of action against physicians who commit such violations.

EMTALA, 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 attention following the Supreme Court's decision in *Dobbs*, in which the 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. These state provisions spurred questions about the interplay between a health care provider's duty to provide care for an emergency medical conditions under EMTALA and state restrictions that limit a health care provider's ability to provide abortion services.

Two weeks after the Court's *Dobbs* decision, CMS issued Guidance addressing EMTALA's obligations related to emergency abortion services. This Guidance generally indicated that EMTALA compels hospital emergency department physicians to provide an abortion when that care is the necessary stabilizing treatment for an emergency medical condition, and that the Act preempted state laws that conflicted with this treatment requirement. In *Texas v. Becerra*, the State of Texas sued the Secretary of HHS and others, claiming that the Guidance exceeded HHS authority. After a district court's grant of a permanent injunction that blocked enforcement of the Guidance in Texas and against the plaintiffs, the U.S. Court of Appeals for the Fifth Circuit agreed with the plaintiffs and affirmed this decision. The Fifth Circuit explained, in part, that "[w]hile EMTALA directs physicians to stabilize patients once an emergency medical condition has been diagnosed, the practice of medicine is to be governed by the states. HHS's argument that 'any' type of treatment should be provided is outside EMTALA's purview." The appeals court also pointed to the Act's definition of "emergency medical condition" and the requirement to provide stabilizing care for both a pregnant woman *and her unborn child* as evidence that EMTALA did not preempt the Texas abortion restrictions. In June 2025, following a change in presidential administration, CMS rescinded the Guidance.

In 2022, HHS sued the State of Idaho, claiming that EMTALA preempted an Idaho state law that criminalizes abortion in most circumstances. After the U.S. District Court for the District of Idaho expressed agreement with the federal government and issued a preliminary injunction that restricted enforcement of the state statute, and following several legislative and judicial developments in the lawsuit, the Supreme Court agreed to hear the case. Nevertheless, in July 2024, in *Moyle v. U.S.*, the Court issued an order indicating that the Court had "improvidently granted" review before judgment. Alongside the Court's order, all nine Justices wrote or joined opinions concurring and/or dissenting in the result. As part of these accompanying opinions, Justices Kagan, Sotomayor, and Jackson maintained that EMTALA requires hospitals to provide abortions as necessary stabilizing care in some emergency circumstances and would preempt Idaho's law to the extent it prohibits EMTALA-covered abortions. By comparison, Justices Alito, Thomas, and Gorsuch expressed that EMTALA does not preempt the Idaho law because the federal law does not require the provision of abortions. Justices Barrett, Kavanaugh, and Chief Justice Roberts suggested that the EMTALA preemption question could turn on issues not sufficiently addressed by the lower courts, including whether statutes like EMTALA that are enacted pursuant to Congress's Spending Clause and that regulate private parties may preempt state law. (For a detailed discussion of the *Moyle* lawsuit, see CRS Legal Sidebar LSB11196, *Supreme Court Allows Emergency Abortions in Idaho but Leaves Litigation Unresolved*, by Wen W. Shen (2024).)

The Supreme Court remanded *Moyle* back to the U.S. Court of Appeals for the Ninth Circuit, but in March 2025, the U.S. government and the State agreed to dismiss the case. However, litigation over the Idaho law and EMTALA continues in *St. Luke's Health System, Ltd. v. Labrador*, a legal challenge to the Idaho law filed by a health care provider in the state. The U.S. District Court for the District of Idaho has issued a preliminary injunction limiting enforcement of the Idaho abortion restrictions against the plaintiff during the pendency of the lawsuit.

Legal Considerations for the 119th 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.

Questions about EMTALA's scope and preemptive effect, particularly in the context of emergency abortion services, remain the subject of litigation. Should Congress deem it appropriate, it may choose to consider legislation that explicitly addresses how EMTALA interacts with state abortion restrictions. Such legislation could clarify EMTALA's preemptive reach and the precise circumstances under which hospitals must provide specified services. Legislation on this issue could affect the outcome of the *St. Luke's Health System* case or any future litigation.

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