A Brief Policy History of the Emergency Medical Treatment and Active Labor Act (EMTALA)

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The Emergency Medical Treatment and Active Labor Act (EMTALA)[1] [2] was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), amid reports of hospital emergency rooms refusing to treat poor or uninsured patients. This federal law requires, as a condition of federal Medicare funding, that hospitals provide certain services to any individual presenting at an emergency department (irrespective of an individual's ability to pay) or face potential enforcement action. Because very few hospitals do not accept Medicare, the law applies to nearly all hospitals. Now 40 years after its enactment, EMTALA continues to provide protections and generate controversy.

Political Momentum

In the mid-1980s, the problem of hospitals turning away ("dumping") people who were uninsured rose onto the political agenda. At that time, this was a widespread and growing practice with largely financial motives. In Dallas, emergency room transfers increased from 70 per month in 1982 to more than 200 per month in 1983 (Zibulewsky, 2001). At the Massachusetts General Hospital Emergency Department, uninsured persons were sent away unserved. (McDonough, 2026). Further attention to patient dumping came as a result of journal articles written by physicians at Chicago's Cook County Hospital, in which the authors defined dumping as "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere" (Schiff et al, 1986). Advocates and news reporters took notice.

Notably, in 1984, before a series of expansions, Medicaid financed only 15 percent of births, many births were to uninsured women, and the cost of maternity care was increasing (Gold and Kenney, 1985; Kenney et al., 1986). As a result, many of those being turned away from hospitals were uninsured pregnant mothers who were in active labor and in need of birthing services. In a 50-state survey about maternal and child health conducted by the Children's Defense Fund, Kay Johnson and Sara Rosenbaum documented multiple instances of mothers in labor being turned away from the hospital, with some giving birth in the parking lot and others losing the baby or dying themselves. Some of the most egregious cases identified were from Dallas.

In Texas, Mike Hudson, then Director of the Children's Defense Fund Texas office, was a prominent and highly effective advocate whose efforts helped shape the anti-dumping policy in the state, which in turn strongly influenced federal legislative action. The vigorous advocacy to protect access to emergency care

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[1] Codified in Social Security Act Section 1867 of the Social Security Act; 42 U.S.C. Section 1395dd. Regulations at CFR 489.24 (Up to date as of July 9, 2026). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-B/section-489.24

[2] P.L. 99-272. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) deleted the word "active" from the title of EMTALA in order to include an array of emergency medical conditions in pregnancy such as early labor, ectopic pregnancy, or fetal loss. Sec. 6211(h)(2)(C) of P.L. 101-239.

for pregnant women was also anchored by people from the health system, such as public health leader David Smith and Dallas' Parkland Hospital CEO Ron Anderson. The state Task Force on Indigent Health Care and its chair Helen Farabee played a role in reporting on the problem. In 1985, as part of the Indigent Health Care and Treatment Act, the Texas legislature passed the nation's first anti-patient dumping law, requiring hospitals to treat or transfer people with medical emergencies regardless of a patient's ability to pay. The regulations to support this law also required transfer of pertinent medical information, patient informing about free or reduced cost care options, and prohibited discrimination against patients based on race, religion, national origin, age, sex, physical condition, or economic status (King, New York Times; Klibanoff, Texas Tribune; Glenza J, The Guardian).

In response to widespread concerns and having a Texas law adopted the prior year, Congress enacted EMTALA in 1986. Bipartisan support from Congress included the voices of Representatives Stark (D-CA-13) and Bilirakis (R-FL-9), and Senators Dole (R-KS), Durenberger (R-MN), Kennedy (D-MA), and Proxmire (D-WI). This included multiple Members of Congress who expressed specific concerns about mothers in labor being turned away from hospitals (APHA et al, 2024).

While discussed in various professional journal articles and by Rosenbaum and her colleagues in the textbook *Law and the American Health Care System,* the details are not widely known regarding how the House and Senate reached bipartisan agreement and why the Reagan administration went along. What we do know is that during hearings and deliberations on this issue, the House Committee on Ways and Means, House Judiciary Committee, and Senate Finance Committee received a disturbing number of reports about how hospital emergency departments were dumping uninsured patients in need of emergency medical treatment. The House Committee on Ways and Means noted its concern:

> "*The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance....*" H.R. Rep. No. 99-241 (Part 1) at 27. Report to accompany COBRA.

Structure of EMTALA

EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual's ability to pay. If a hospital determines that the person has an emergency medical condition, it must provide treatment to stabilize the condition or provide for transfer to another appropriate facility. (GAO-01-747). Under EMTALA, an emergency medical 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 part*s." With respect to pregnant women, the statute specifically mentions those in labor and those having contractions. Broadly, an emergency medical condition in pregnancy includes one that endangers the health of the woman or her unborn child, which might include obstetric conditions such as ectopic pregnancy and non-obstetric related emergency conditions such as appendicitis or trauma from motor vehicle accidents (CRS, 2023).

When hospitals fail to follow the law, penalties may be levied. The HHS Office of Inspector General (OIG) may seek a Civil Monetary Penalty against any hospital that has been found to have negligently violated its obligations under EMTALA (OIG, 2024).

Factors Affecting Implementation

EMTALA's implementation was neither simple nor expedited. Over four decades, implementation has been guided by three sources across our three branches of government: 1) statutory language from the legislative branch, 2) guidelines issued by the federal Medicaid agency (then the Health Care Financing Administration-HCFA, and now the Centers for Medicaid and Medicaid Services-CMS) from the

executive branch,[3] and 3) multiple federal court decisions from the judicial branch. By 1988, Congress continued to hear about numerous cases of egregious dumping practices across the country and found that the US Department of Health and Human Services (HHS) had failed to issue regulations implementing EMTALA, placing thousands of patients at risk. Interpretive Guidelines were first issued in 1998 (with several subsequent updates). In November 1999, CMS and the OIG jointly issued a Special Advisory Bulletin that focused on the implementation of EMTALA in a managed care environment. Over the years, EMTALA also has generated controversy that led to lawsuits. (Zibulewsky, 2001). Many, many court decisions have influenced how states, hospitals, and patients understand this law.

Between 2014 and 2024, implementation of the Affordable Care Act (ACA) greatly expanded both Medicaid and marketplace coverage, which significantly decreased the number of individuals 18-64 years who are uninsured. The increases in coverage post ACA were associated with a substantial decrease in EMTALA violations and settlements. (McKenna et al., 2018).

Post-Dobbs Action

Since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*,[4] questions have arisen about the relationship of EMTALA to state laws, particularly in the context of emergency abortion services. In *Dobbs*, the Supreme Court concluded that the U.S. Constitution does not confer a right to an abortion. After the decision, many states passed bans on abortion services, and studies suggest that a substantial rise in maternity related EMTALA violations has occurred in some states (Woskie et al., 2025). A central legal question is 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.

The Biden Administration repeatedly affirmed that EMTALA preempts state laws that would restrict access to abortion in emergency situations. In July 2022, the Biden Administration released guidance regarding *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss*, which reaffirmed that EMTALA requires health providers to offer necessary stabilizing care—including abortion care—for patients experiencing emergency medical conditions. This guidance indicated 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, then 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" (CRS, 2023).

Also in July 2022, in *Texas v. Becerra*, the State of Texas sued to block enforcement of the EMTALA, with a preliminary injunction issued.[5] In August 2022, in *United States v. Idaho*, HHS sued the State of Idaho to block enforcement of its abortion ban to the extent it conflicts with EMTALA, an injunction was issued to temporarily stop Idaho from enforcing its law, and then the Supreme Court blocked the injunction which permits Idaho to enforce its law (Rosenbaum, 2024). On March 5, 2025, the US Department of Justice reversed its position and ended its challenge to Idaho's abortion ban. These two courts made disparate and conflicting decisions. (Mello, 2022). Additional legal challenges are ongoing KFF, 2026; (Keith, 2026).

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[3] On June 14, 2001, the Secretary of HHS changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS).

[4] *Dobbs v. Jackson Women's Health Org*., 597 U.S. 215, 339 n.2 (2022).

[5] No. 5:22-CV-185-H 022 WL 18034483, at 1-3 (N.D. Tex.) Nov. 15, 2022.

On June 3, 2025, HHS and CMS rescinded the Biden Administration guidance on EMTALA. The Trump Administration concluded that pursuant to the preliminary injunction in *Texas v. Becerra*, HHS may not enforce the following interpretations contained in the July 2022 CMS guidance (and the corresponding letter sent the same day by HHS Secretary Becerra). They stated that:

> (1) HHS may not enforce the Guidance and Letter's interpretation that Texas abortion laws are preempted by EMTALA; and
> (2) HHS may not enforce the Guidance and Letter's interpretation of EMTALA —both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against the members of the American Association of Pro-Life Obstetricians and Gynecologists and the Christian Medical and Dental Association (CMS.gov).

In an interview in 2024, Sara Rosenbaum, professor emerita at the Milken School of Public Health at the George Washington University, is quoted about the policy context, saying: "Nobody was thinking about EMTALA," when Roe v. Wade was overturned. "Except for the handful of us who are really, really steeped in EMTALA, we knew the day would come when the states' standards would come into direct conflict with EMTALA" (Klibanoff, Texas Tribune).

For pregnant people who need care for emergency conditions, it is almost certainly the case today that health providers, emergency departments, and hospitals across the country are unsure about what care to provide under state and federal laws and how to meet their obligations under EMTALA (Grünebaum et al., 2026; Chernoby and Acunto, 2024). For decades EMTALA has protected the ability of all people to receive stabilizing and life-saving care in emergency situations, including those who are pregnant and need abortions or other stabilizing care. Already, EMTALA violations have increased in states with abortion bans, with many involving obstetric emergencies (Roush, 2026). The current legal context results in confusion, fear, and delays in care that put both mothers and infants at heightened risk for death.

As warned at previous times, complacency about EMTALA adherence is unwarranted (Dame, 1998). More challenges lie ahead. EMTALA violations were widespread when many people were uninsured and then were less common when ACA coverage expansions reduced the number of adults who were uninsured. In 2027 and beyond, as more people in ACA Medicaid expansion states lose coverage due to work reporting requirements and others lose Medicaid as states seek to offset budget shortfalls in response to OBBBA, the number of uninsured people will grow. We can expect more failures to comply with EMTALA at hospitals across the nation. Moreover, as state abortion laws continue to evolve and courts make future decisions, access to birthing and abortion services will be affected (Kurzweil and Floyd, 2026).

Although only 4 pages in length, EMTALA is considered one of the most comprehensive laws guaranteeing nondiscriminatory access to emergency medical care and thus to health care. As Rosenbaum has written: "*Despite ongoing questions that flow from its detailed provisions, EMTALA is an enduring testament to society's evolving views that hospitals must provide emergency care not only to their established patients but to the broader communities they serve*" (Rosenbaum, 2013).

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