Order Code RS22738
Updated May 8, 2008

CRS Report for Congress

EMTALA: Access to Emergency Medical Care

Edward C. Liu
Legislative Attorney
American Law Division

Summary

The Emergency Medical Treatment and Active Labor Act (EMTALA) ensures universal access to emergency medical care at all Medicare participating hospitals with emergency departments. Under EMTALA, any person who seeks emergency medical care at a covered facility, regardless of ability to pay, immigration status, or any other characteristic, is guaranteed an appropriate screening exam and stabilization treatment before transfer or discharge. Since its enactment in 1986, the differing interpretations of the statute's requirements by various courts and the Department of Health and Human Services (HHS) have resulted in conflicts, several of which remain unresolved.

Overview

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA)[1] to address the problem of "patient dumping" in hospital emergency departments.[2] Although attempts to facilitate indigent access to emergency health care already existed in state and federal law, legal frameworks prior to EMTALA were plagued with poor enforcement mechanisms and vague standards of conduct.[3] Amid graphic media reports of hospitals sending away critically ill patients without proper stabilization treatment and delivery rooms unwilling to accept indigent or uninsured women in labor, Congress passed EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.[4]

---

[1] P.L. 99-272, 100 Stat. 164 (1986) *codified at* 42 U.S.C. § 1395dd *et seq*. (2007).

[2] "Patient dumping" occurs when a hospital turns away indigent or uninsured persons seeking treatment so that the hospital will not have to absorb the cost of treating them.

[3] Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS OF HEALTH LAW 145, 146-147 (2004) (discussing the Hill-Burton Act and state statutory and common law). *See also* H.Rept. 99-241, pt. 3, at 5 (1985) (discussing state remedies).

[4] Lee, *supra* note 3 at 147-148, 151. In 2003, Congress appropriated $1 billion over fiscal years 2005-2008 to reimburse hospitals for medical care provided to undocumented aliens. Two thirds (continued...)

EMTALA's statutory scheme has traditionally been deconstructed into two principal categories: 1) provisions that ensure an appropriate medical screening, and 2) provisions that require stabilization before transfer or discharge.[5] EMTALA only requires stabilization of whatever *emergency* conditions a hospital detects, and does not provide a right to indefinite care for anyone who comes to an emergency room. Hospitals and physicians that fail to comply with these requirements may be fined $50,000 and/or excluded from participation in Medicare, and hospitals may additionally be civilly liable to persons who suffer personal injury.[6] EMTALA's sanctions may be suspended by the Secretary of Health and Human Services during national emergencies and were most recently suspended in the Gulf Coast region during Hurricane Katrina's landfall in 2005.[7]

The Screening Requirement

Only hospitals that 1) participate in Medicare and 2) maintain an emergency department are required to *screen* patients under EMTALA.[8] Hospitals that do not have a "dedicated emergency department" are not subject to the screening requirement of EMTALA.[9] Similarly, emergency care providers that are unaffiliated with a hospital need not comply with EMTALA, even where those providers are the only medical care facilities reasonably accessible.[10] For example, in *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, the First Circuit declined to extend EMTALA protections to a 24-hour

---

[4] (...continued)
of the appropriated money is allotted to the states based upon the number of undocumented aliens in each state. The remaining third is allotted to the six states with the highest numbers of apprehended undocumented aliens. P.L. 108-173, Title X, Subtitle B, § 1011, 117 Stat. 2432 (2003). Reimbursement is handled by CMS's designated contractor, TrailBlazer Health Enterprises, LLC. CMS, *Overview: Service Furnished to Undocumented Aliens*, May 22, 2006, *available at* [http://www.cms.hhs.gov/UndocAliens/01_overview.asp].

[5] 42 U.S.C. § 1395dd(a), (b).

[6] 42 U.S.C. § 1395dd(d). Civil fines are limited to $25,000 for hospitals with fewer than 100 beds. *Id.* at (d)(1)(A). Private suits may not be brought against physicians individually. *See e.g. Heimlicher v. Steele*, 442 F. Supp. 2d 685 (N.D. Iowa 2006) (citing *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994), *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993), and *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872 (4th Cir. 1992)). Medicare termination appears to be infrequently invoked as a sanction. Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J. L. & POLICY 695, 701 n. 29 (2006) (stating that between 1986 and 2001 only four hospitals had their Medicare agreements terminated).

[7] 42 U.S.C. § 1320b-5(b)(3). *See* Waiver Under Section 1135 of the Social Security Act, Michael O. Leavitt, Secretary of the Department of Health and Human Services, (Sept. 4, 2005), *available at* [http://www.hhs.gov/katrina/ssawaiver.html]. Sanctions are only lifted for inappropriate transfers or redirections. 72 Fed. Reg. 47,385 (Aug. 22, 2007).

[8] 42 U.S.C. § 1395dd(a), (d)(1)(A), and (e)(2). Although the screening and stabilization requirements are phrased such that they apply to "hospitals" generally, enforcement of EMTALA is only authorized against hospitals that have entered into a Medicare provider agreement. *Id.*

[9] 42 U.S.C. § 1395dd(a). A dedicated emergency department is defined as any facility that is licensed or held out to the public as such, or that provides urgent care to one third of its outpatients during the preceding calendar year. 42 C.F.R. § 489.24(b).

[10] *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, 402 F.3d 45 (1st Cir. 2005).

emergency room clinic in rural Puerto Rico because the clinic was not associated with a hospital. The Federal District Court for the District of Puerto Rico had initially held that, because the clinic was the primary provider of 24-hour emergency health care in its area, applying EMTALA to the clinic best furthered the statutory goal of universal access to emergency medical care.[11] However, the First Circuit reversed, holding that any considerations of the goals of Congress were inappropriate where the text of the statute was clear.[12]

The screening requirement is triggered when an individual "comes to the emergency department" of a hospital *and* requests to be treated.[13] Under HHS regulations, an individual may be deemed to have come to the emergency department in certain circumstances, even though the individual is not physically present in the emergency department or elsewhere on the hospital campus.[14] For example, a patient en-route to a hospital in an ambulance or air transport owned by that hospital has "come to the emergency department" of that hospital and may not be refused a screening exam under EMTALA. These regulations also state that incoming patients in ambulances that are not owned by the receiving hospital *have not* "come to the emergency department," and may be redirected if the hospital is in "diversionary status."[15] However, at least one federal court of appeal has rejected this interpretation of the statute and has held that EMTALA could be triggered by an incoming ambulance that was *not* owned by the receiving hospital.[16] In either case, should an ambulance ignore a redirection request, EMTALA is triggered when the patient physically arrives at the redirecting hospital.[17]

What constitutes an "appropriate screening exam". Although hospitals with dedicated emergency departments are required to perform screening exams, it is not

---

[11] *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, 263 F. Supp. 2d 297 (D. Puerto Rico 2003) (arguing that the nature of the services provided should be determinative, not whether a facility is defined as a hospital).

[12] *Rodriguez v. American Int'l*, 402 F.3d at 49 (noting that Congress was free in drafting the statute to extend EMTALA to rural clinics unaffiliated with hospitals, but had not done so). EMTALA does apply to facilities designated as "critical access hospitals," which provide 24-hour emergency services and acute inpatient care to rural areas. 42 U.S.C. § 1395dd(e)(5).

[13] 42 U.S.C. § 1395dd(a). Requests for treatment may be made on the individual's behalf and a request may be implied if a prudent layperson observer would believe that the individual needs emergency medical care. 42 C.F.R. § 489.24(b) (2006).

[14] 42 C.F.R. § 489.24(b). The campus includes areas within 250 yards of a hospital's main buildings. 42 C.F.R. § 413.65(b).

[15] 42 C.F.R. § 489.24(b). A hospital is in diversionary status if it lacks the staff or facilities to treat additional emergency patients. *See also Arrington v. Wong*, 237 F.3d 1066, 1072 (9th Cir. 2001) (reasoning through negative implication that a hospital may not divert an ambulance if it is *not* in diversionary status).

[16] *Morales v. Sociedad Española de Auxilio Mutuo y Beneficencia*, No. 07-1951, slip op. 14-15 (1st Cir. Apr. 18, 2008) (relying in part on potentially ambiguous language in the regulations).

[17] 42 C.F.R. § 489.24(b). Prior to the promulgation of these regulations, the Seventh Circuit had held that contacting a hospital via telemetry alone does not invoke EMTALA. *Johnson v. Univ. of Chicago Hosps.*, 982 F.2d 230 (7th Cir. 1993). These regulations are consonant with that holding.

necessarily a violation of EMTALA if a screening exam falls short of either a local or national medical malpractice standard.[18] The language of the statute requires only "an appropriate medical screening exam."[19] The majority of the federal circuits have held that, because the chief evil sought to be prevented was the lack of access for uninsured patients, an "appropriate" exam is one comparable to what a paying patient would receive under similar circumstances.[20] However, the Sixth Circuit has construed the statute more narrowly, holding that there is no violation of EMTALA without the additional allegation of an "improper motive" that led to a substandard screening exam.[21]

The Stabilization Requirement

Like the screening requirement, the stabilization requirement applies to all Medicare participating hospitals with a dedicated emergency department. However, in some cases the stabilization requirement may also apply to a Medicare participating hospital even if it does not have an emergency department. For example, if treatment of an individual's medical condition requires a particular hospital's unique equipment or expertise, federal regulations compel that hospital to accept a transfer of that patient from any nearby U.S. hospital.[22]

The stabilization requirement is triggered when a hospital discovers that an individual has an emergency medical condition. Actual knowledge of an emergency medical condition is required.[23] Therefore, if a hospital fails to accurately detect an individual's emergency condition and discharges that individual without stabilizing the medical condition, the hospital may not have violated EMTALA's stabilization provisions. However, the hospital may still be civilly liable to the individual based upon state medical malpractice claims if the failure to detect an emergency condition was due to negligence during the screening exam.[24]

Interpretations of the stabilization requirement. Except where medically necessary, hospitals must ensure that an individual is stabilized before discharge or

---

[18] *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790 (10th Cir. 2001) (noting that EMTALA was not enacted to create a federal medical malpractice standard).

[19] 42 U.S.C. § 1395dd(a). Screening exams may vary based upon a hospital's capabilities and the nature of an individual's request. 42 C.F.R. § 489.24(a)(i) and (c).

[20] *Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir. 1995), *Baber v. Hosp. Corp. of America*, 977 F.2d 872 (4th Cir. 1992), *Marshall v. E. Carroll Parish Hosp. Serv.*, 134 F.3d 319 (5th Cir. 1998), *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996), *Jackson v. E. Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001), *Holcomb v. Monahan*, 30 F.3d 116 (11th Cir. 1994), *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037 (D. C. Cir. 1991).

[21] *Cleland v. Bronson Health Care Group, Inc.*, 917 F2d 266, 272 (6th Cir. 1990). Gender, race, nationality, financial insolvency, bias against a particular medical condition, and personal animosity were examples of improper motivation offered by the *Cleland* court.

[22] 42 C.F.R. § 489.24(f). Examples of specialized equipment or expertise include burn units, shock-trauma units, neonatal intensive care units, or regional referral centers.

[23] 42 U.S.C. § 1395dd(b)(1) and 42 C.F.R. § 489.24(a)(1)(ii).

[24] *Bryant v. Adventist*, *infra* note 28 at 1166.

transfer. Federal regulations define an individual as stabilized as either 1) when there is a reasonable assurance that no material deterioration would result from that individual's transfer or discharge from the hospital or, 2) in the case of women in labor, after delivery of the child and placenta.[25] Unlike the screening requirement, the language of the stabilization requirement does not qualify the care to be given as "appropriate."[26] Based on this textual distinction, the U.S. Supreme Court has held that no "improper motive" need be alleged to show a violation of EMTALA's *stabilization* provisions.[27]

Stabilization and inpatient status. When an emergency medical condition is detected, a hospital may decide to admit the individual as an inpatient for further treatment. Whether the stabilization requirement continues to apply to patients after they have been admitted is a disputed issue. Because the statute only defines "stabilization" in the context of transfers, the Fourth, Ninth and Eleventh Circuits have held that a hospital has no stabilization duties that are enforceable under EMTALA once an individual has been admitted.[28] However, the Sixth Circuit disagreed in *Thornton v. Southwest Detroit Hosp*.[29] In that case, a stroke victim alleged she was discharged from the ICU without being stabilized, in violation of EMTALA, after 21 days of inpatient care. The Sixth Circuit held that EMTALA still required stabilization before discharge, despite her inpatient status.[30]

The Supreme Court declined to rule on this issue in *Roberts v. Galen*, although it had an opportunity to do so.[31] However, during oral arguments for that case, an Assistant Solicitor General, arguing as *amicus curiae*, informed the Court that the Department of Health and Human Services intended to begin rule-making procedures to provide guidance on this question.[32] In 2002, the Centers for Medicare and Medicaid Services (CMS) issued a notice of a proposed rule extending EMTALA protections to inpatients.[33] Many solicited comments pointed to the *Bryant v. Adventist*[34] decision holding

---

[25] 42 C.F.R. § 489.24(b).

[26] 42 U.S.C. § 1395dd(b)(1)(A).

[27] *Roberts v. Galen*, 525 U.S. 249, 252-3 (1999). The Court expressly declined to decide whether the "improper motive" requirement was required with respect to EMTALA's screening provisions. *Id.* at 253 n.1. *See also supra* notes 20-21 and accompanying text.

[28] *Bryan v. Rectors & Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), *Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1168-1169 (9th Cir. 2002), *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002).

[29] *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990).

[30] The Sixth Circuit argued in dictum that if EMTALA did not apply to inpatients, hospitals could avoid EMTALA liability by admitting, and immediately discharging, a patient. *Id.* at 1135.

[31] *Roberts v. Galen*, 525 U.S. at 253-4 n.2.

[32] Transcript of Oral Argument at 17-20, *Roberts v. Galen*, *supra* note 26. The Solicitor General also argued that the question of inpatient status had not been properly raised in the courts below.

[33] Notice of Proposed Rule, 67 Fed. Reg. 31,403, 31,475-6 (May 9, 2002).

[34] *Bryant v. Adventist Health Sys.*, 289 F.3d at 1168-1169.

otherwise,[35] and in 2003, CMS reversed its position, stating that if, after performing a screening exam, a hospital admits an individual for treatment of an emergency medical condition, then the hospital has satisfied its duties under EMTALA.[36]

Stabilization of known emergency conditions. The stabilization requirement may preempt certain state laws authorizing physicians to decline administering treatment where deemed inappropriate based upon their medical judgment. In *In re Baby K*, a hospital sought a declaratory judgment that they were permitted to refuse to treat an anencephalic infant in respiratory distress.[37] The hospital argued that the prevailing standard of care for anencephalic infants was to provide warmth and nutrition without mechanical respiration, and that Virginia state law authorized physicians to refuse to provide care they believed would be inappropriate.[38] The Fourth Circuit disagreed and held that the requirement of stabilization prior to transfer or discharge was compulsory once an emergency medical condition had been identified by hospital personnel, even where the treating physician believed stabilization treatment would have been futile. Furthermore, the court held that EMTALA preempted the Virginia statute authorizing the physician to refuse to provide treatment he reasonably believed to be inappropriate.[39]

Requirements for transfers after stabilization. All transfers must be conducted with qualified personnel and equipment. An individual may not be transferred unless the receiving hospital consents to receive the individual. The receiving hospital must have the capacity and expertise to treat the transferred individual, and all medical records must be sent to the receiving hospital. It is the transferring hospital's obligation to ensure that the transfer has been performed as described above and the transferring hospital remains liable under EMTALA until an appropriate transfer is completed.[40] It is not a violation of EMTALA to transfer an individual who has not been stabilized when it is medically necessary to do so. In such situations, a qualified medical person, as defined by the hospital's own rules and regulations, must certify that the benefits of transfer to a different facility outweigh the risks involved.[41]

---

[35] Notice of Final Rule, 68 Fed. Reg. 53,221, 53,243-5 (Sept. 9, 2003). Comments also expressed concerns that EMTALA would usurp existing protections for inpatients.

[36] 42 C.F.R. § 489.24(d)(2). Inpatients are still protected by other Medicare conditions of participation. Persons admitted for elective treatment or diagnosis are still covered under EMTALA. *Id.*

[37] *In re Baby K*, 16 F.3d 590 (4th Cir. 1994).

[38] *Id.* at 596-7.

[39] *Id.* EMTALA explicitly preempts any state laws that directly conflict with EMTALA's provisions. 42 U.S.C. § 1395dd(f). The Fourth Circuit later clarified *Baby K's* holding in *Bryan v. Univ. of Virginia*, ruling that EMTALA only mandates treating a patient's emergency medical condition, not the patient's general medical condition. *Bryan v. Univ. of Virginia*, 95 F.3d at 352. Therefore, had the hospital admitted Baby K after stabilizing her emergency respiratory distress, it would not have been required to then treat her underlying anencephaly beyond warmth and nutrition. *Id.*

[40] 42 C.F.R. § 489.24(e)(2).

[41] 42 C.F.R. § 489.24(e)(1)(ii)(B).