SAFEGUARDING ACCESS TO EMERGENCY PREGNANCY CARE

State Level Protections Are Urgently Needed to Address the Emergency Abortion Care Crisis.

June 2025

Across the country, pregnant people are being denied life-saving emergency care, especially in states where abortion is illegal or severely restricted.[i] These denials have only increased since the 2022 Dobbs decision when the U.S. Supreme Court eliminated the constitutional right to abortion, opening the door for states to ban abortion altogether.[ii] The federal Emergency Treatment and Labor Act (EMTALA) was enacted to ensure hospitals treat patients during a medical emergency or active labor.[iii] However, on June 3, 2025 the Trump administration repealed guidance reminding hospitals that they must provide emergency abortion care. To be clear, rescinding this guidance does **not** change hospitals' legal obligation to provide emergency abortion care. However, it invites chaos into emergency rooms — deepening confusion for hospitals navigating abortion bans and making it even easier for care to be delayed or denied when patients need it most. States must act now to codify emergency pregnancy care protections into their own laws. It is what pregnant people deserve and the public supports — **86% of women of reproductive age agree that individuals experiencing pregnancy-related emergencies should have access to life-saving abortion care.**[iv]

EFFORTS TO UNDERMINE FEDERAL EMTALA PUT PREGNANT PATIENTS AT RISK

Congress enacted EMTALA nearly 40 years ago because private hospitals routinely transferred patients to public hospitals, even during active labor or a medical emergency.[v] EMTALA requires covered hospitals to provide emergency care, regardless of a patient's ability to pay. There are times when ending a pregnancy is required to stabilize a patient during an emergency—such as when their water breaks prematurely and the pregnancy is not viable or they have an ectopic pregnancy, where the embryo implants into a fallopian tube. The premature rupture of membranes can result in sepsis and an ectopic pregnancy can cause the fallopian tube to burst. Both conditions can be life threatening if not treated promptly. EMTALA requires hospitals to provide the minimal of level of care a pregnant person experiencing an emergency deserves. Despite this, and the clear legal requirements—even in states where abortion remains legal—hospitals have delayed or denied emergency abortion care. In some cases, this has led to permanent injury or death. **These denials are not hypothetical; they are documented, devastating, and ongoing.**

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WE DO NOT HAVE TO IMAGINE WHAT DENIAL OF EMERGENCY ABORTION CARE LOOKS LIKE

Health care providers and hospitals in states with abortion bans may delay care for fear of criminal prosecution, resulting in widespread denials of emergency treatment. After Texas enacted a six-week abortion ban—followed by a total ban—the rate of sepsis among pregnant patients hospitalized for second-trimester miscarriages rose by more than 50%.[vi] This increase reflects not just a medical crisis, but a political one: as providers face legal uncertainty and the threat of prosecution, they are delaying or denying care—even in emergencies. **These delays have had fatal consequences.**

TEXAS, OCT. 29 2024

Eighteen-year-old Naveah Crain was experiencing a miscarriage when she was turned away from the emergency room three times in less than 24 hours. **By the time she was finally admitted, it was too late to save her.**[vii]

GEORGIA, AUG. 19 2022

In Georgia, under a six-week abortion ban, Amber Nicole Thurman was denied the abortion care needed to address a life-threatening infection. **She died of sepsis just 20 hours after being admitted to the hospital.**[viii]

Denials of emergency abortion care are happening even in states with strong legal protections for reproductive freedom. One significant driver of these denials is the growing influence of religiously affiliated hospitals, which often invoke conscience-based objections to refuse abortion care—even when a patient's life, health, or future fertility is at risk.[ix]

The state of California, for example, recently sued a Catholic hospital for denying emergency abortion care to Anna Nusslock. After her water broke when she was 15 weeks pregnant, Providence Hospital in Eureka California refused to treat Anna even though her pregnancy was no longer viable.[x] She was forced to travel 12 miles to the nearest hospital for emergency care while actively hemorrhaging. That hospital has since closed its labor and delivery unit, leaving pregnant patients in the area with nowhere else to go. This case illustrates a broader problem: federal EMTALA alone cannot guarantee emergency abortion access when hospitals exploit religious exemptions or when local capacity is already strained. **State EMTALA legislation that builds upon and strengthens the federal standard is urgently needed—not only to protect patients' health, fertility, and lives, but to create state-level accountability mechanisms that don't depend on shifting federal enforcement priorities.**

STATES MUST ENACT EMERGENCY PREGNANCY PROTECTIONS

The escalation in attacks against those who provide and receive abortion care is not theoretical. The Trump administration has taken multiple actions to undermine EMTALA. Under the Trump Administration, the Department of Justice dropped a federal lawsuit seeking to enforce EMTALA in Idaho, a state with a total abortion ban. Although St. Luke's, the state's largest health care system, filed its own lawsuit, the real world consequences of non-enforcement are already clear.[xi]

During the 3-month period when Idaho was allowed to apply its ban even in emergency situations, St. Luke's had to airlift 6 patients out of state so they could end their pregnancies to protect their health.[xii]

In June 2025, the Trump administration repealed guidance reminding hospitals that they must provide emergency abortion care. This guidance, issued by the Biden administration following the U.S. Supreme Court's 2022 decision overturning Roe, reminded hospitals of the longstanding requirement to provide abortion care when needed to stabilize a patient during a medical emergency, including in states that ban abortion. The administration's callous decision to withdraw this guidance not only threatens pregnant patients' health, lives, and safety but is pulled straight from the pages of Project 2025 —the widely circulated policy blueprint for a second Trump term — which explicitly calls for removing emergency abortion care from EMTALA's scope.

While rescinding this guidance does **not** change hospitals' legal obligation to provide emergency abortion care, it deepens confusion for hospitals, especially those navigating abortion bans, and makes it even easier for delays and denial of care when patients need it most. **States cannot afford to wait.** They must act now to establish their own emergency pregnancy care protections—not only to reinforce existing federal requirements, but to future-proof access in the face of the federal rollback. Illinois has already enacted such a law, and similar bills are gaining momentum across the country. These efforts provide a model: state EMTALA legislation can reaffirm the obligation to provide stabilizing care, update statutory language to reflect clinical realities, and protect providers who act in accordance with medical standards—even when political conditions shift.

STATES WORK TO SOLIDIFY PROTECTIONS FOR EMERGENCY PREGNANCY CARE

In response to coordinated efforts by anti-abortion extremists to ban emergency abortion care, lawmakers introduced state-level EMTALA legislation to mirror and build upon the federal law's requirements. In 2024, **four states** (Connecticut, Illinois, Maryland, and Pennsylvania) introduced bills that would explicitly require hospitals licensed in those states to provide abortion care when needed to resolve an emergency medical condition.

Illinois became the first state to enact such legislation, reinforcing the federal EMTALA mandate while making clear that emergency abortion care is protected under state law. The Illinois statute also includes provisions that expand provider protections and clarify enforcement mechanisms.[xiii]

This year, **at least seven additional states** (California, Colorado, Connecticut, Maryland, Massachusetts, New York, and Washington) have introduced emergency care legislation that mirrors or builds upon EMTALA's requirements. These state-level actions reflect a growing recognition that federal protections are increasingly vulnerable to political manipulation and judicial rollback. With ongoing litigation and the threat posed by a federal administration hostile to reproductive rights, states are working proactively to enshrine emergency abortion care as a legal requirement and public health imperative.

STATE EMTALA LEGISLATION PROTECTS ACCESS TO CARE AND CAN ADVANCE HEALTH EQUITY

Legal access to emergency care is not experienced equally. Even in states without formal abortion bans, persistent inequities and structural barriers prevent many patients from receiving timely, appropriate care. State EMTALA legislation offers a strategic opportunity to address these gaps and create a more equitable standard of care.

By codifying emergency pregnancy care protections into state law, lawmakers can respond directly to the erosion of federal safeguards while also reinforcing the principle that every patient—regardless of income, race, geography, or immigration status—deserves access to life-saving care.

TO IMPROVE HEALTH EQUITY STATES MUST CONSIDER POLICIES RESPONSIVE TO EXISTING BARRIERS:

Folks living in rural areas must often travel long distances to the nearest hospital with an emergency room.

It is unclear how far a person would have to travel if hospitals are permitted to resume patient dumping.

Discriminatory practices within the medical system exacerbate already dire maternal health outcomes.

There are also conditions that disproportionality contribute to a higher Black maternal mortality rate across states, including hypertensive disorders such as preeclampsia.

The criminalization of pregnancy outcomes especially among Black, Indigenous, and communities of color, as well as low-wage workers.

This includes the weaponization of fetal homicide and child neglect laws to criminalize Black women and people of color even in states with abortion protections.

Religiously affiliated hospitals use provider 'conscience' laws to deny emergency abortion care even when a patient's life or health is at risk.

PUSHING BEYOND EMTALA: CONSIDER THE FOLLOWING PROVISIONS TO ADVANCE STATE EMERGENCY CARE LEGISLATION

Apply to all emergency departments in the state

Require every hospital licensed in the state with an emergency department to provide emergency services regardless of a patient's insurance status or ability to pay.

Require abortion care

Mandate abortion care when needed to stabilize a pregnancy-related emergency. We know emergency medical care includes abortion. However, an explicit abortion care requirement responds to the ongoing pregnancy-care crisis in which patients are denied emergency abortions in states where abortion is illegal and protected.

Include anti-discrimination protections

Require the provision of services to any person who seeks emergency care. Consider explicit protections to prohibit denial of care based on a person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, sex, race, color, religion, disability, sexual orientation, primary language, or immigration status.

Defend providers

Include language shielding providers from penalties for providing emergency care, including abortion **or** alerting the state of a hospital's failure to comply.

Avoid "personhood" language

Require emergency pregnancy care without mirroring EMTALA's reference to the "unborn child." Instead use "the pregnancy."

Avoid citing to federal EMTALA

Incorporate the federal law's requirements into state law instead of citing to the federal law. Federal law and its interpretation can change so it is important to have state protections that are independent of the federal EMTALA.

APPENDIX

STATE EMTALA LEGISLATION INTRODUCED IN 2025

CALIFORNIA

A.B. 40 if enacted, would amend the state's existing emergency care law to make abortion an explicit type of care required under the definition of "Emergency services and care."

COLORADO

S.B. 25-130 makes abortion an explicit emergency medical service, requires hospitals to log outcomes, prohibits discrimination in emergency care services, and specifies pregnancy-related conditions that trigger emergency care requirements. This bill has been enacted and took effect on May 14, 2025.

CONNECTICUT

H.B. 7287 if enacted, would require hospitals to provide emergency reproductive care, specifies miscarriage and ectopic pregnancy as conditions that trigger emergency care requirements, and establish anti-discrimination protections for patients and providers. The bill directs the Department of Public Health to adopt rules if the federal statute is revoked or is inadequately enforced.

MARYLAND

S.B. 447 directly mirrors the federal statute and would codify EMTALA's requirements into state law but does not explicitly require emergency abortion care. This bill has failed.

MASSACHUSETTS

S.D. 1858 if enacted, would require hospitals to provide emergency abortion care, specify pregnancy-related conditions that trigger emergency care requirements and prohibit religious refusal for emergency abortion care.

NEW YORK

S. 3007 C requires hospitals to provide emergency abortion care, explicitly requires screening pregnant patients for active labor, and includes anti-retaliation protections for health care providers. This bill has been enacted and took effect on May 9, 2025.

WASHINGTON

S.B. 5557 incorporates existing state regulations requiring pregnancy termination during a medical emergency in state law and prohibits prioritizing the continuation of the pregnancy or the health of the embryo or fetus over the pregnant person. This bill has been enacted and took effect on April 29, 2025.

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ENDNOTES

i Kimberly Chernoby, et al., Pregnancy Complications After Dobbs: The Role of EMTALA, 25 W.J. Emergency Med. 79 (Jan. 2024). See also Rachana Pradhan, Why Hospitals in Many States With Legal Abortion May Refuse To Perform Them, KFF Health News (March 5, 2024)

ii Dobbs v. Jackson Women's Health Organization, 597 U.S. 215, 232 (2022).

iii 42 U.S.C. § 1395dd.

iv Schumacher et al., KFF Health Tracking Poll March 2024: Abortion in the 2024 Election and Beyond, KFF(Mar.7, 2024)

v Pub. L. 99-272, title IX, § 9121(c).

vi Texas Banned Abortion. Then Sepsis Soard. ProPublica (Feb. 20, 2025)

vii Lizzie Presser, A Pregnant Teenager Died After Trying to Get Care in Three Visits to Texas Emergency Rooms , ProPublica (Nov. 1, 2024

viii Kavitha Surana, Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable, ProPublica (Sept. 16, 2024)

ix Rachana Pradhan, Why Hospitals in Many States With Legal Abortion May Refuse To Perform Them, KFF Health News (March 5, 2024)

x Attorney General Bonta: California DOJ is Ready to Defend Reproductive Rights at Tomorrow's Hearing on Providence ST. Joseph Hospital Lawsuit, State of California, Department of Justice (Feb. 13, 2025)

xi Alice Miranda Ollstein, Trump admin moves to drop fight over emergency abortions, reversing Biden admin stance, Politico (March 4, 2025)

xii Kelcie Moseley-Morris, New court order shields certain Idaho doctors from prosecution for emergency abortion care, Idaho Capital Sun (March 21, 2025)

xiii H.B. 581 § 1, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 210 Ill. Comp. Stat. 80/1)