**Case No.: 23-726**
**Vided: 23-727**

# In The Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,

*Petitioners,*

v.

THE UNITED STATES OF AMERICA,

*Respondent.*

IDAHO,

*Petitioner,*

v.

UNITED STATES,

*Respondent.*

**On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit**

## BRIEF OF WOMEN HURT BY ABORTION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS


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## INTEREST OF *AMICI CURIAE*[1]

*Amici* 2,739 Women Injured by Abortion[2] are women who were injured by their own abortions and their abortionists. Most of the *Amici* Women Injured by Abortion suffered grievous psychological injuries, but many suffered severe physical complications as well. All were exposed to the risk of serious physical injury, as well as serious psychological injuries,[3] and thus have a profound interest in protecting other women from such injuries. All of the *Amici* Women have experienced abortion.

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici Curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

[2] Attached as Appendix A is the list of the initials, first names, or full names of the *Amici Curiae* Women. In order to protect their identities, some of the women have requested that we use initials only or first name only. These women's sworn affidavits or declarations made under penalty of perjury are on file at The Justice Foundation. Protecting the identity of women who have had abortions or seek abortions has been customary since *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), where *Roe* and *Doe* both were pseudonyms.

Link to Appendix: https://www.dropbox.com/scl/fo/c51kufzrilpfcfdu3uh2r/h?rlkey=se5iq7ycbs98y0z97epctc7jv&dl=0.

[3] *See*, *e.g.*, "Women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion." *See* Coleman, Priscilla, "Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009," British J. Psychiatry (2011) 199, 180-186, DOI: 10.1192/bjp.bp.110.077230 (meta-analysis of 22 studies).

*Amici* Women have experienced first-hand—some multiple times—the callous reality of the abortion industry. They and the vast majority of women who go to high volume abortion facilities are treated as a business asset or customer, not as a patient. Therefore, the word "patient" will not be used in this Brief because there is no real doctor-patient relationship in most abortion facilities, only the technical or legal fiction of a doctor-patient relationship. It is standard practice for a woman to not even see her doctor until she has paid her money and is prepped for the abortion. With the increased use of chemical abortion and telemedicine abortion, this "relationship" is even more attenuated and transactional. A normal doctor-patient relationship does not exist despite the fundamental expectation espoused in *Roe v. Wade*, 410 U.S. 113 (1973) (reversed by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022)) (hereafter "*Roe*").

*Amici* Women know and experienced firsthand the misrepresentations and substandard health practices of the abortion industry in practice. *Amici* Women, in this brief, will provide this Court with post-abortion women's perspectives on abortion.

## SUMMARY OF ARGUMENT

HHS and DOJ are asserting authority that was not delegated to them by Congress. Under the Spending Clause of the Constitution, States may only be bound by federal laws infringing on their historic police powers when a "contract" is created between the State and the federal government. No such contract exists within Medicare, of which EMTALA is a part.

Even if the Court somehow concluded that EMTALA was binding on States, EMTALA is still part of Medicare. Medicare is subject to the Hyde Amendment, which prohibits federal funds for abortions except in case of rape, incest, or the life of the mother. Idaho's statute protecting life provides substantially the same exceptions as the Hyde Amendment, so there would be no reason to enjoin Idaho's statute protecting life.

Abortion is a medical procedure, but it is not healthcare. As a medical procedure, abortion is in the category of euthanasia and execution by lethal injection, because its purpose is the death of a human being. None of these procedures are healthcare.

## ARGUMENT

### I. The federal government has no equitable remedy against the State of Idaho vis-à-vis EMTALA

#### A. The federal government has no equitable remedy against a State law conflicting with a Spending Clause statute unless the State has accepted the federal "contract"

##### 1. Supremacy Clause preemption of State law is not a separate Congressional power

The United States and the District Court have dealt with preemption as if it is a separate power of Congress. But this Court has explained that preemption merely determines who wins a conflict. It cannot create a conflict, and it cannot invalidate a duly enacted State law without an independent grant of authority. *Murphy v. NCAA*, 584 U.S. 453, 477 (2018) ("Preemption is based on the Supremacy Clause, and that Clause is not an independent grant of legislative power to Congress. Instead, it simply provides 'a rule of decision.'") (citing *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 324 (2015)).

For preemption to apply, a federal statute "must represent the exercise of a power conferred on Congress by the Constitution; pointing to the Supremacy Clause will not do." *Murphy*, 584 U.S. at 477. This is because "the Framers explicitly chose a Constitution that confers upon Congress the power to regulate

individuals, not States." *New York v. United States*, 505 U.S. 144, 166 (1992).

Yet all of DOJ's arguments have merely pointed to the Supremacy Clause and EMTALA's provisions, without looking at what power was exercised by Congress. *See*, *e.g.*, JA 4 ("To the extent Idaho's law prohibits doctors from providing medically necessary treatment, including abortions, that EMTALA requires as emergency medical care, Idaho's new abortion law directly conflicts with EMTALA.").

As part of Medicare, EMTALA was enacted under the spending power. Therefore, EMTALA is bound by the Constitutional restrictions of that power. "Where the recipient of federal funds is a State, as is not unusual today, the conditions attached to the funds by Congress may influence a State's legislative choices." *New York*, 505 U.S. at 167. This is the "contract" required in *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). And no contract is present here.

### 2. A federal Spending statute can only conflict with a State law where the State has expressly accepted the federal contract that provides funds and conditions

Congress may authorize federal spending even where it may not directly regulate. "[T]he constitutional limitations on Congress when exercising its spending power are less exacting than those on its

authority to regulate directly." *South Dakota v. Dole*, 483 U.S. 203, 209 (1987).

However, Spending Clause legislation comes with a very important caveat.

This Court held that: "The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' . . . [W]e enable the States to *exercise their choice* knowingly, cognizant of the consequences of their participation." *Pennhurst*, 451 U.S. at 17 (emphasis added).

States do not—and cannot—exercise choice over Medicare, because Medicare does not require any State participation to be active in every State.

### B. EMTALA is part of Medicare and is active in every State through participation of individuals and hospitals, regardless of State choice and without State participation

Other parties have correctly argued that the Medicare "contract" and associated EMTALA restrictions do not impose abortion (or any other specific procedure) on Medicare-participating hospitals. As those briefs show, that decision is left by EMTALA to the States.

However, before even reaching the question of what terms are imposed by the Medicare "contract," the United States must pass the threshold issue of

showing that such a "contract" was ever created by Congress. Congress avoided creating such a contract by forgoing the State participation section that is present in other Spending Clause legislation, such as Medicaid. *See*, *e.g.*, 42 U.S.C. § 1396-1 ("The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance."). And, in this case, the United States has not even attempted to show that Congress made such provision.

Without Congressional authority to preempt State laws relating to the practice of medicine, HHS may not claim federal law preempts a State law relating to the practice of medicine.

Yet, the HHS Secretary's guidance unlawfully attempts to radically expand EMTALA's statutory authority by claiming "[a]nd when a state law prohibits abortion and does not include an exception for the life and health of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—that state law is preempted."[4]

The same assertion of authority expressed in the guidance also formed the basis for this case. As explained below, this guidance is *ultra vires*.

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[4] *Memorandum: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-22-22-Hospitals)*, Dep't of Health & Human Serv., July 11, 2022 (emphasis in original) [hereinafter "Memo"].

### 1. Unlike Medicaid, Medicare and EMTALA do not create a contract between States and the federal government

This Court has repeatedly held that a Spending Clause contract can only be created by an intentional act of Congress that constitutes an offer, and an act by the State that constitutes an acceptance. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.").

Medicare and Medicaid are administered by the same agency and were created at the same time, but have very different modes of operation. Medicaid is a federal program offering funding to States in exchange for creating a medical program. *Gallardo v. Marstiller*, 142 S. Ct. 1751, 1755 (2022) ("States participating in Medicaid must comply with the Medicaid Act's requirements or risk losing Medicaid funding.") (internal citation omitted). On the other hand, Medicare is a program offered to individuals, in which medical service providers may choose to participate. *Becerra v. Empire Health Found.*, 142 S. Ct. 2354, 2359 (2022) ("The Medicare program provides Government-funded health insurance to over 64 million elderly or disabled Americans.") and *ibid.* ("The Medicare program pays a hospital a fixed rate for treating each Medicare patient. . . .").

By its text and Congressional intent, Medicaid creates a federal-State contract. Medicaid provides that it is only effective in States which join the program. 42 U.S.C. § 1396-1 ("The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.").

By contrast, Medicare became effective for individuals throughout the United States when enacted. States had no option to accept or reject Medicare becoming effective in their States or for their citizens at passage, nor can any State opt out of Medicare. Qualifying individuals may choose whether or not to join Medicare, and medical service providers may choose whether or not to participate, but States have no such choice.

Therefore, Medicaid provides the terms and reciprocal obligations necessary for contract formation between the federal government and States. Medicare does not.

If Congress had wanted EMTALA obligations to apply to States, Congress could have chosen to place EMTALA in Medicaid. Instead, Congress intentionally placed EMTALA within Medicare, making EMTALA subject to 42 U.S.C. § 1395 ("*Nothing in this title* [42 USCS §§ 1395, et seq.] shall be construed to authorize *any Federal officer or employee* to exercise *any supervision or control* over the *practice of medicine* or the manner in which medical services are provided. . . ."). Under the Spending Clause, EMTALA must be part of

a federal-State contract to bind states. There is no contract.

The executive branch and HHS may not claim more power than was delegated to them by Congress. The HHS guidance at issue in this case was clearly *ultra vires*, in addition to the fact that it was also issued in violation of the APA, in addition to the fact that abortion obligations were not considered by the Congress that passed EMTALA, and especially in addition to the fact that EMTALA requires stabilizing—not killing—an unborn child. All of these reasons are extremely important to *Amici* Women Injured by Abortion.

### 2. Medicaid cases that required abortion hinged on the State's voluntary participation in Medicaid

Although this Court has not ruled on whether State laws may protect infant life *in utero* against abortions deemed medically necessary by Medicaid, each federal appellate court to examine the issue has concluded that State laws more restrictive than Medicaid were preempted under the Supremacy Clause. *Planned Parenthood Affiliates v. Engler*, 73 F.3d 634, 638 (6th Cir. 1996) (collecting cases).

The precedential value of these cases is highly questionable in light of *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2238 (2022) ("Roe and Casey have led to the distortion of many important but unrelated legal doctrines, and that effect provides

further support for overruling those decisions."). *Amici* would argue those cases are now overruled *sub silentio* by *Dobbs*, if the issue were before the Court.

However, regardless of *Dobbs'* implications, these holdings relied upon State participation in Medicaid for federal authority. *Engler*, 73 F.3d, at 638; *Hope Medical Group for Women v. Edwards*, 63 F.3d 418, 425 (5th Cir. 1995); *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 172 (3d Cir. 1995).

These cases uniformly make clear that States subject themselves to Medicaid funding restrictions only by choosing to participate in Medicaid. This Court held that: "The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' . . . [W]e enable the States to *exercise their choice* knowingly, cognizant of the consequences of their participation." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (emphasis added). It follows that States would *not* be subject to Medicaid funding restrictions if they did *not* participate in Medicaid.

In the same way that a State choosing not to participate in Medicaid cannot have its duly enacted laws preempted by Medicaid, a State that cannot participate in Medicare cannot have its duly enacted laws preempted by Medicare. The only possible exception is that the United States may potentially vindicate a statutory right created by EMTALA. *See* discussion in I.C, *infra*.

#### 3. To put a pin in it, the typical remedy for a State failing to comply with conditions in Spending Clause legislation is to terminate funds to the State—an impossibility here.

As articulated by this Court in *Pennhurst*, the federal government's expected course to enforce Spending Clause legislation against States is to cut off State funds. *Pennhurst*, 451 U.S., at 28 ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather *action by the Federal Government to terminate funds to the State*."). In other words, if the State violates the contract, the federal government is not obligated to continue funding it.

The "typical" action described in *Pennhurst* is impossible here because there are no funds to terminate. There are no State funds connected to EMTALA to terminate because *there is no contract*.

### C. EMTALA creates limited federal statutory rights which only provide remedies against *hospitals* and *physicians*

#### 1. Congress did not implicitly confer a statutory right or obligation on doctors to perform abortions

For the DOJ argument to prevail, they must show that Congress intended to confer a statutory right or obligation *on hospitals or physicians* nationwide to

*perform* abortions. If this right existed it could only be implicit, because EMTALA does not mention abortion. *See generally* 42 U.S.C. § 1395dd. *Amici* contend there could never be an implicit statutory right to *perform* an abortion, and the concept of a "right" to kill other women's babies *in utero* is gruesome.

A claim that Congress intended to regulate the State practice of medicine is insufficient, because Congress could not have done so under the spending power without State agreement. *See* discussion in Section I.B, *supra*.

### 2. EMTALA statutory rights and remedies are fully described within the EMTALA statute

This Court has found that statutory remedies tend to foreclose implied remedies. *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001) ("The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.").

The statutory rights and remedies created by EMTALA are fully described in the enforcement section of the EMTALA statute. 42 U.S.C. § 1395dd(d). Federal government remedies include the right of the Secretary of HHS to sanction a hospital (§ 1395dd(d)(1)(A)), or sanction a physician (§ 1395dd(d)(1)(B)). In addition to this EMTALA-specific remedy, Medicare allows the Secretary to terminate a hospital's participation in the Medicare program for multiple reasons, including non-compliance with EMTALA. 42 U.S.C. § 1395cc(b)(2)

("The Secretary may . . . terminate such an agreement after the Secretary . . . has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title [42 USCS §§ 1395, et seq.] and regulations thereunder[.]"). Neither EMTALA nor Medicare generally has any such termination provision with respect to States—because States do not participate in EMTALA or Medicare generally. These statutorily prescribed remedies by HHS involve the only parties that the EMTALA statute binds—hospitals and physicians.

The EMTALA statute also creates private rights of action for an individual to obtain damages for EMTALA violations by a hospital (§ 1395dd(d)(2)(A)) and for a medical facility to obtain damages for EMTALA violations by another hospital (§ 1395dd(d)(2)(B)). All of these causes of action may only be brought against hospitals which choose to participate in Medicare. *See*, *e.g.*, § 1395dd(d)(2)(A) ("Any individual who suffers personal harm as a direct result of a *participating hospital's violation* of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury *under the law of the State* in which the hospital is located, and such equitable relief as is appropriate.") (emphasis added); § 1395dd(d)(1)(B) ("Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss,

under the law of the State in which the hospital is located, and such equitable relief as is appropriate.").

Every appellate Court to examine it has held that only Medicare participating hospitals are liable under EMTALA. *See*, *e.g.*, *Rodriguez v. Am. Int'l Ins. Co.*, 402 F.3d 45, 47 (1st Cir. 2005) ("EMTALA imposed some limited substantive requirements on emergency rooms of hospitals participating in the federal Medicare program."); *Zelda v. Dublier*, 741 Fed. Appx. 397, 399 (9th Cir. 2018) ("Thus, as the EMTALA only provides a form of redress against a participating hospital, the only proper Defendant in this matter is Harborview Medical Center.").

These cases uniformly interpret EMTALA to provide limited statutory rights for certain individuals against hospitals and for the HHS Secretary against physicians and hospitals.

Critically, the provided actions never discuss remedies against States or State laws, except a single boilerplate preemption clause. *See* 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section."). The United States' complaint hangs its *entire case* on this provision by relying on mere conclusory legal statements.

### 3. The United States' assertion of authority requires violating the basic canon of statutory interpretation that Courts should presume Congress was acting Constitutionally

Any federal regulatory action which requires more authority than what is conferred by Congress is *ultra vires* under the Administrative Procedures Act. 5 U.S.C. § 706(2)(C) ("The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . in excess of statutory jurisdiction, authority, or limitations, or short of statutory right."); *Accord City of Arlington v. FCC*, 569 U.S. 290, 299 (2013) ("To exceed authorized application is to exceed authority."). If this Court discerns that HHS' assertion of authority would conflict with State law, but the EMTALA statutory text (which provides authority for HHS action) would not conflict with State law, then the Court may end its inquiry by finding the HHS assertion of its authority is *ultra vires*.

The HHS' assertion of authority in this case requires that the Court construe EMTALA and Medicare outside the bounds of the Spending Clause, upon which its authority rests. Congress could not have intended EMTALA to preempt State laws regulating the practice of medicine, because Congress placed EMTALA within Medicare, a Spending Clause statute with no State-federal contract. *See* Section I.B.1, *supra*.

HHS' assertion of authority therefore requires an unconstitutional interpretation of EMTALA. But

Courts must construe statutes in a way that does not violate the Constitution, if possible. *Rust v. Sullivan*, 500 U.S. 173, 191 (1991) ("'[A] statute must be construed, if fairly possible, so as to avoid not only the conclusion that it is unconstitutional but also grave doubts upon that score.' This canon is followed out of respect for Congress, which we assume legislates in the light of constitutional limitations.") (citing *FTC v. American Tobacco Co.*, 264 U.S. 298, 305-307 (1924)).

Therefore, this principle forecloses any HHS argument that EMTALA contains provisions regulating the practice of medicine in the States.

#### 4. Idaho's abortion law does not interfere with the statutory rights created by EMTALA

A state law could only conflict with the objects and purposes of EMTALA if the law interfered with the statutory rights of patients or medical facilities to sue hospitals (for example, by immunizing hospitals from EMTALA suits created by 42 U.S.C. § 1395dd(d)) or if the law required patient dumping (which would interfere with a patient's statutory rights granted under § 1395dd(c)). Abortion is nowhere in sight among these rights. So long as a statute does not contravene the objects and purposes of EMTALA, and complying with EMTALA and State law is possible, then there is no preemption.

Because the Idaho statute does not contravene the objects and purposes of EMTALA, and complying with

EMTALA and state law is possible, there is no preemption.

The federal government states that hospitals are placed in the impossible position of complying with HHS guidance and Idaho statute. This is only true if we assume its conclusory legal statement (which is completely unsupported) about EMTALA is true. JA 4 ("To the extent Idaho's law prohibits doctors from providing medically necessary treatment, including abortions, that EMTALA requires as emergency medical care, Idaho's new abortion law directly conflicts with EMTALA."). As discussed in Section I.D.2, *infra*, the federal government never even alleges the State-federal contract required for such broad preemption to exist.

HHS is quite correct that it is not possible to comply with Idaho statute and its own EMTALA *guidance*. But that conflict is by the design of HHS, not Congress. It is quite possible to comply with Idaho statute and the EMTALA *statute*. This places the HHS guidance outside the authority of the EMTALA statute and the HHS guidance is therefore *ultra vires*.

#### 5. States do not participate in any State-federal contract in Medicare, generally, or in EMTALA, specifically

The principle that States may not be paid by Medicare has been consistently applied by Courts of Appeals. *See Massachusetts v. Sebelius*, 638 F.3d 24, 28

(1st Cir 2011). States may not directly apply for Medicare reimbursements, where the State Medicaid agency improperly paid for services. Instead, the doctor or hospital which provided the services must refund the money to the State agency, and the provider must seek reimbursement under Medicare.

This is the exact position advocated by the Center for Medicare and Medicaid Services ("CMS") in cases involving Medicare payments to States. *Ibid.* ("CMS wrote that 'there is no statutory authority under Medicare to allow a state to seek recovery and be paid directly from Medicare' because 'Medicare allows only providers to bill and be paid by Medicare.' ").

The only mechanisms within Medicare that involve the States are ancillary agreements for state agencies to provide HHS with information on medical providers within the States and for federal grants. *See*, *e.g.*, 42 U.S.C. § 1395aa(a) (statutory authority to enter agreement with States to assess compliance of service providers); 42 U.S.C. § 1395z (statutory authority to consult with State agencies to develop conditions for participation by service providers in Medicare Part E); 42 U.S.C. § 1395v (statutory authority for HHS to form agreements with States to automatically enroll eligible citizens in Medicare Part B). These ancillary agreements have no impact on whether Medicare becomes or remains operative in the State. In addition, these agreements are entirely self-contained, with their own conditions and reciprocal obligations for federal and State participation. *See*, *e.g.*, 42 U.S.C. § 1395i-4 (providing grants for States that establish

Rural Hospital Flexibility Programs, along with the requirements for State participation). Individuals and medical service providers within the State remain eligible for services and reimbursement regardless of State participation in these ancillary agreements. And all agreements remain subject to Medicare's first section, which prohibits federal interference in the practice of medicine within a State. 42 U.S.C. § 1395 ("Nothing in this title [Medicare] shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . . .").

If EMTALA had been placed in Medicaid (42 U.S.C. §§ 1396, et seq.), § 1395 would not apply. There is no provision in Medicaid that is comparable to § 1395. In addition, States would have the option to accept or decline EMTALA funding restrictions to participate in Medicaid. Congress instead chose to place EMTALA within Medicare, 42 U.S.C. § 1395dd. Courts and HHS must respect Congress' decision not to require States to conform their health regulations to EMTALA or any other Medicare funding restrictions.

### D. With no Spending Clause contract in Medicare between Idaho and the federal government, the federal government has no Constitutional Supremacy Clause remedy against the State of Idaho

#### 1. The federal government has no discernable legal interest in unwarranted interference in a State law that does not violate the Constitution

In its decision below, the Ninth Circuit panel correctly observed that "improperly preventing Idaho from enforcing its duly enacted laws and general police power also undermines the State's public interest in self-governance free from unwarranted federal interference." JA 706.

In provider agreements, hospitals which voluntarily participate in Medicare must agree to comply with EMTALA. 42 U.S.C. § 1395cc(a)(1)(I)(i) (a Medicare participating hospital must "ensure compliance with the requirements of [EMTALA] and [] meet the requirements of such section[.]").

EMTALA and Medicare place no similar requirement on States, and never purport to bind States to conform their health regulations to EMTALA or *any* Medicare provision.

In its decision, the district court gets this argument exactly backwards, claiming that Idaho is

arguing for a broad constitutional holding. However, it is the United States that is attempting to interpret (or misinterpret) the statute in a manner that would be unconstitutional. *See* discussion in Section I.C.3, *supra*.

Medicare specifically disclaims any supervision or control over the practice of medicine:

> *Nothing in this title* [42 USCS §§ 1395, et seq.] shall be construed to authorize *any federal officer or employee* to exercise *any supervision or control* over the *practice of medicine* or the manner in which medical services are provided . . . *or to exercise any supervision or control over the administration or operation of any [Medical] institution, agency, or person*.

42 U.S.C. § 1395. Courts uphold regulations within this context. *See*, *e.g.*, *Goodman v. Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989) (upholding a *hospital* regulation under Medicare) ("Here the Secretary's regulation does not presume to supervise or control the practice of medicine. The regulation does not actually direct or prohibit any kind of treatment or diagnosis.").

And all circuits to examine it have consistently held that EMTALA does not create a national standard of care. *Bryant v. Adventist Health System/West*, 289 F.3d 1162, 1166 (9th Cir. 2002) ("EMTALA, however, was not enacted to establish a federal medical malpractice cause of action nor to establish a national standard of care."); *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1141 (8th Cir. 1996) (en

banc) ("EMTALA also does not establish a national standard of care."); *Vickers v. Nash Gen. Hosp.*, 78 F.3d 139, 141 (4th Cir. 1996) ("[EMTALA] is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment[.]").

### 2. HHS and DOJ have never claimed in this case (much less argued) that Congress intended to bind States with EMTALA, even though their proposed remedy depends on it

The Department of Justice, on behalf of the United States of America, claimed in its complaint that hospitals receiving Medicare funds are required to perform abortions. The DOJ explained that Idaho Code § 18-622 prohibits abortions. The DOJ explained the penalties for violating § 18-622. Then the DOJ concluded that the laws directly conflict, and that the Idaho law is preempted. *See* JA 3-4.

Unlike factual allegations, bare legal contentions are not entitled to an assumption of truth in a complaint. *Cf. Indep. Towers of Wash. v. Washington*, 350 F.3d 925, 930 (9th Cir. 2003) ("We require contentions to be accompanied by reasons."). The DOJ has—to this day—never provided reasons which support its implicit contention that the State of Idaho must have accepted the federal spending contract in Medicare.

This is true even though DOJ's complaint has an entire section entitled "Idaho's Abortion Law Conflicts

with EMTALA," as that section also never alleges that Idaho accepted the federal Medicare contract. *See* JA 12-14.

The same is true in their brief before the Ninth Circuit. Despite spending 4 pages unpacking EMTALA, the DOJ never mentions the federal contract required of Spending Clause statutes under *Pennhurst*. *See* Section I.A.2, *supra*. The DOJ does not make this argument even though it dedicates a section of its brief to the Spending Clause. This absence demonstrates the weakness of the DOJ position. *See* Consol. Br. U.S. to 9th Cir. (Sept. 8, 2023), 44-45.

As explained more fully in Section I.B, *supra*, this omission is fatal to DOJ's case and demands dismissal of its suit. EMTALA simply does not preempt State laws regulating medicine. *See* discussion in Section I.C.2, *supra*.

### 3. The United States has no legal remedy in this case

Because there is no Spending power contract, and because state regulations of the practice of medicine do not touch on any rights conferred by EMTALA on individuals, the DOJ has no framework to invoke preemption. This is clear from its complaint and in every argument it has made since then.

## II. In the alternative, even if EMTALA bound States, EMTALA does not demand a State perform abortions prohibited by the federal Hyde Amendment

### A. The federal government may not compel a State to provide services that Congress is unwilling to fund

The Supreme Court examined the impact of the Hyde Amendment on abortion mandates in *Harris v. McRae*, 448 U.S. 297 (1980). At the time of *Harris*, abortions were only federally funded under the Hyde Amendment where necessary to save the life of the mother. HHS claimed that States were still required to perform abortions deemed medically necessary, even if they were not funded because of Hyde.

After upholding the constitutionality of the Hyde Amendment, the *Harris* Court held that the federal government could not use Medicaid to require States to allow abortions that were not funded by Hyde. *Id.* at 309 ("Title XIX [Medicaid] was designed as a cooperative program of *shared* financial responsibility, not as a device for the federal Government to compel a State to provide services that Congress itself is unwilling to fund.") (emphasis added).

This settles the issue. Any abortions that are not funded because of Hyde are also not required by Medicare, which includes Hyde language.

### B. The Hyde Amendment prohibits federal funds from being used for abortions except to save the life of the mother or in cases of rape or incest

The fiscal year 2023 version of the Hyde Amendment, as applicable to both Medicare and Medicaid, is P.L. 117-328. Div. H, §§ 506–507 (Dec. 29, 2022). The language of Hyde prohibits funding for abortions in § 506(a) ("None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.") but allows funding for certain abortions in § 507(a) (abortions are funded "if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.").

Taken as a whole, the 2023 Hyde Amendment only provides funds for abortions in cases of rape, incest or to save the life of the mother. This specifically does not fund abortions as claimed in the DOJ's complaint. JA 13 ("For example, EMTALA requires stabilizing treatment where "the health" of the patient is "in serious jeopardy," or where continuing a pregnancy could result in a "serious impairment to bodily functions" or a "serious dysfunction of any bodily organ or part."). The scenarios alleged by DOJ are not within the ambit of Hyde, and therefore DOJ's claim that these preempt

State law is contrary to this Court's precedent in *Harris*, 448 U.S. at 309 (the federal Government may not "compel a State to provide services that Congress itself is unwilling to fund"). *See also* discussion in Section II.B, *supra*.

## III. Abortion is not healthcare and not within the ambit of EMTALA

### A. Abortion is not healthcare under EMTALA, the Constitution, or the ordinary meaning of the term

Merriam-Webster defines health care as "efforts made to maintain, restore, or promote someone's physical, mental, or emotional well-being especially when performed by trained and licensed professionals." *Health care*, MERRIAM-WEBSTER DICTIONARY (Online edition, Feb. 16, 2024), https://www.merriam-webster.com/dictionary/health%20care. *Killing* another human being (as with an abortion) does not maintain, restore, or promote *the killed* human's well-being, and therefore does not fall within this definition.

This Court has specifically excluded acts which kill a human being from substantive due process protections, including the right to abortion and the right to suicide. *See*, *e.g. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990) ("We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."); *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 250 (2022) ("The inescapable conclusion is that a right to abortion is not deeply rooted

in the Nation's history and traditions."). The logical inference from these cases is that abortion is not healthcare under the Constitution.

Within EMTALA, the type of healthcare required is "[n]ecessary stabilizing treatment for emergency medical conditions and labor." 42 U.S.C. § 1395dd(b). This requires that the hospital provide "such treatment as may be required to stabilize the medical condition." § 1395dd(b)(1)(A). The act further defines emergency medical condition to include conditions "placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy." § 1395dd(1)(A)(i).

The strong inference is that abortion is the *only procedure excluded* by the statutory text of EMTALA, at least in the case of a woman in labor.

### B. An abortion is the intentional termination of the life of a whole, separate, unique, living human being

Abortion has been defined at law in South Dakota as "the intentional termination of the life of a human being in the uterus." S.D. Codified Laws § 34-23A-1(1). The Eighth Circuit upheld a South Dakota law requiring doctors to tell mothers that "the abortion will terminate the life of a whole, separate, unique, living human being" even under the old *Roe* framework. S.D. Codified Laws § 34-23A-10.1(1)(b). *See Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 737-738 (8th Cir. 2008) (en banc) (the required statutory disclosure is "truthful, non-misleading and

relevant to the patient's decision to have an abortion"). This required warning was upheld even in the face of abortionists' First Amendment rights. *Id.* at 737 ("Planned Parenthood's asserted threat of irreparable harm [to its free speech] is correspondingly weakened in comparison to the State's (and the public's) interest in providing pregnant women with all possible relevant information about abortion.").

Even under the now-defunct *Roe* framework, the Supreme Court frequently held that abortion is *sui generis*. *Harris v. McRae*, 448 U.S. 297, 325 (1980) ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.").

Idaho women have a federal Constitutional right to keep their children. *Maher v. Roe*, 432 U.S. 464, 472 (1977) (citing *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942)) ("Indeed, the right of procreation without state interference has long been recognized as "one of the basic civil rights of man . . . fundamental to the very existence and survival of the race."). But no one has a federal Constitutional right to abort a child. *See generally Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

### 1. Taking a life is not healthcare, even when it is a medical procedure

Abortion is the killing of an infant life at the moment of the abortion. In *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007), this Court stated, " . . . it seems

unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained." Elective abortion is similar in kind to other non-healthcare medical procedures. Medical procedures which involve intentionally killing a human being include euthanasia, execution by lethal injection, and abortion. These procedures are not healthcare.

*Amici* Women Injured by Abortion testify to the truth of the statement that abortion took the life of their child. Here is what they experienced:

Jennifer

> "Abortion has been the most destructive and hurtful thing in my life. I wasn't told about the many emotional consequences, I was expected to just move on. After my abortion, I felt hollow on the inside. A part of me died that day, physically and emotionally in addition to the killing of my own baby . . . Abortion destroyed my life for 12 years. I had issues with severe depression, I had suicidal thoughts shortly after, I hated myself for choosing the abortion."

Mary Lee

> "The moment I walked out the door of the abortion clinic I was different. Not only the physical pain I had but the emotional pain was so deep I didn't understand. I started drinking heavily to deaden the pain. I kept it a secret for 20 years and it ate a huge hole in my heart. Every time I saw or heard the word abortion I would cry and go into a dark

> depression period. Every Year around the anniversary of my abortion I would sob uncontrollably and would be depressed for weeks."

Joanne

> "I don't feel that the people running the clinic explained that the pain would last a long time. I almost died from my abortion. The doctor left part of the baby and placenta attached and I was rushed in to emergency surgery to stop hemorrhaging. I was told it would be quick and painless. But, I was hurt very deeply and it wasn't painless physically either."

What *Amici* experienced was not healthcare. Their pain was not from the lingering physical effects of a medical procedure, but from the medical certainty that they had their own child killed.

Healthcare practitioners should not be salespeople for any procedure. Yet, the risks of abortion were routinely minimized for these *Amici*, and its benefits were overstated or fabricated by an industry that promotes the abortion procedure to anyone who will listen. Many *Amici* women report being told their child was a "clump of cells" or "mass of tissue" being removed from their bodies—like liposuction—not an infant being killed.

M.C. from Michigan

> "I was told there would be minor cramping, it would be very fast, there would minor pain, the fetus would not feel anything, it was not developed enough to feel pain yet. I can say

> that was the worst pain I have ever felt in my life, I asked them to stop almost as soon as it started and I was told they couldn't stop. It was dangerous and I needed to be quiet. I was scaring the other patients with my yelling and crying. Two other staff members came in to hold me still and quiet me."
>
> S. from Georgia
>
> "I was told there were no consequences or adverse effects from the abortion. It would be just like having a bad period afterward would be the worst side effect. The guilt I felt was quite extreme and I still deal with it sometimes. My periods became much worse (very heavy bleeding and cramping that I have had to have surgery for). My next pregnancy was not able to come to full term due to the placenta not staying attached to the uterus. If it were illegal I never would have done it."
>
> Suzanne
>
> "I was not told it was a living baby. I was told it was a blob of tissue and it was the best solution for me, a 16 yr. old girl. I was not told of the hurt or the sense of emptiness, guilt and shame that I would feel. I was not told of the lingering pain."

These quotes are the tip of the iceberg for the 2,739 *Amici* who have joined together for this brief.

### 2. The abortion industry argues it should not be held to the standards of healthcare practitioners

The abortion industry routinely rejects and argues against basic healthcare standards being applied to them.

For example, the abortion industry has argued for decades in Court that its abortion providers need not be doctors. *Mazurek v. Armstrong*, 520 U.S. 968, 969-970 (1997) (reversed by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022)) ("The Montana law was challenged almost immediately by respondents, who are a group of licensed physicians and one physician-assistant practicing in Montana.").

It has argued that its practitioners need not have admitting privileges in a nearby hospital. *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 591 (2016) (reversed by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022)) ("[A] group of Texas abortion providers filed an action in federal District Court seeking facial invalidation of the law's admitting-privileges provision.").

It has argued that it need not provide patients with written informed consent. *Planned Parenthood v. Casey*, 505 U.S. 833, 845 (1992) (reversed by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022)) ("the petitioners, who are five abortion clinics and one physician representing himself as well as a class of physicians who provide abortion services, brought this suit seeking declaratory and injunctive relief. Each

provision was challenged as unconstitutional on its face." The challenged provisions included written informed consent.).

It has argued it does not need to provide patients with ultrasounds. *See*, *e.g.*, *Stuart v. Camnitz*, 774 F.3d 238, 245 (4th Cir. 2014) ("The physicians urge us to find that the [ultrasound] regulation must receive strict scrutiny because it is content-based and ideological.").

In short, the abortion industry has maintained for generations that it is different in kind from healthcare practitioners. Abortionists demand not to be treated like healthcare providers because they do not consider themselves to *be* healthcare providers.

The federal government assumes the opposite, without argument. It is arguing that not only is abortion healthcare, but that abortion is actually necessary under EMTALA. JA 3 ("In some circumstances, medical care that a state may characterize as an 'abortion' is necessary emergency stabilizing care that hospitals are required to provide under EMTALA."). Furthermore, by claiming that Medicare-participating hospitals must perform abortions, the federal government is recruiting emergency room doctors—actual purveyors of healthcare—to perform abortions. In effect, this argument attempts to convert every Medicare-participating hospital in the United States into a *de facto* abortion clinic.

### 3. Procedures like ectopic pregnancy removal are healthcare, not abortions, because the taking of human life is not the aim

Removing an ectopic pregnancy is not a criminal abortion because the purpose of the removal is to save the life of the mother, not to kill the child.

However, "terminating a pregnancy," when *not* medically necessary to save the life of the mother, has the purpose of killing the child. This is a criminal abortion, because it is the purposeful killing of a child.

It is illogical to claim that EMTALA requires killing an infant for a cause *other than* saving the life of the mother, because this places the procedure outside of the healthcare arena, into an elective *physical* procedure not intended to preserve the patient's *physical* health.

Medicare does not concern healthcare regulations or criminal behavior. States retain complete power to regulate healthcare and criminal activity, so far as Medicare is concerned.

Doctors and/or patients can't transform the intentional killing of a child *in utero* into healthcare, regardless of their preferred labels.

## CONCLUSION

*Amici* believe this lawsuit is a transparent attempt by an ideological government agency to collaterally attack laws which protect women, like *Amici*, from making a decision that caused them permanent injury and their children death.

If the DOJ, or any pregnant Idaho woman, believes that the Idaho abortion prohibition is unconstitutional, they should make that argument in a facial challenge to Idaho's law. They would lose:

> These legitimate interests [in limiting abortion] include respect for and preservation of prenatal life at all stages of development; the protection of maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.

*Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 301 (2022) (internal citation omitted).



## PRAYER

Without a Supremacy Clause remedy, no relief is permissible against the State of Idaho, and the United States has not stated a claim under which relief may be granted. *Amici* respectfully pray the Court will

remand the case to the District Court with instructions to dismiss with prejudice.

Respectfully submitted,

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