No. 23-726

In the Supreme Court of the United States

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

Petitioners,

v.

UNITED STATES,

Respondent.

ON WRIT OF CERTIORARI BEFORE JUDGMENT TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF

EMTALA does not preempt state abortion laws. EMTALA generally supplements state law, extending a Medicare-participating hospital's duty of care to the hospital's front door. It does not "override" state healthcare laws down to "specific treatments," legal or not, provided in emergency rooms. *Contra* U.S.Br.33-36, 47. EMTALA's default rule is that it does "not preempt" and thus operates alongside such laws. 42 U.S.C. §1395dd(f). Nor is there anything to "override" in Idaho. Idaho's Defense of Life Act prohibits criminal abortions, not medical treatment for the pregnancy conditions proffered by the Government. There is no direct conflict between that exercise of the State's police powers and EMTALA.

The Government recasts EMTALA to empower the Executive Branch to set a nationwide standard of emergency care. It hands HHS a line-item veto over state healthcare laws. It ignores what the Idaho Supreme Court has said about Idaho law and what Congress has said about federal abortion laws. There is nothing "narrow" about that preemption theory. Congress did not, "through muffled hints," "effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice" in most emergency rooms nationwide. *Gonzales v. Oregon*, 546 U.S. 243, 274-275 (2006). That unprecedented power is irreconcilable with the major questions doctrine, the Spending Clause, and the Tenth Amendment's promise of dual sovereignty.

I. EMTALA Operates Alongside Idaho's Defense of Life Act.

A. EMTALA's default rule is that it does "not preempt" state law.

The Government frames this case as one "about the meaning of EMTALA's stabilization requirement." U.S.Br.12. That's only half right. This case is about preemption, and the text of EMTALA's non-preemption provision controls. *See* 42 U.S.C. §1395dd(f); *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 517 (1992). That provision "necessarily contains the best evidence of Congress' pre-emptive intent," *Sprietsma v. Mercury Marine*, 537 U.S. 51, 62-63 (2002), not a free-wheeling inquiry about whether EMTALA should require what the Government now calls "pregnancy termination" and used to call "abortion care."[1] *See* Leg.Br.20-23, 35-36.

1. EMTALA does not purport to occupy the field of emergency medicine. Just the opposite—EMTALA codifies the presumption against preemption. *See Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). Section 1395dd(f) "is an express disclaimer of preemption." *De Veau v. Braisted*, 363 U.S. 144, 157 (1960) (plurality op.); *see* Leg.Br.22-23. It states EMTALA's "provisions … do not preempt" state law and excepts only that which "directly conflicts" with an EMTALA "requirement." §1395dd(f).

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[1] *Compare, e.g.*, U.S.Br.9, *with* Gov't C.A.Br.15 (Sept. 8, 2023), *and* CMS, *QSO-22-22-Hospitals* (July 11, 2022) (*QSO-22-22-Hospitals*), Leg.App.33 (if "abortion is the stabilizing treatment necessary to resolve that condition, the physician **must** provide that treatment").

The Government turns EMTALA's presumption against preemption on its head. The Government insists that "[n]othing in EMTALA's operative text suggests that state law limits EMTALA's mandate to provide stabilizing treatment." U.S.Br.35. EMTALA's "very purpose," the Government says, "was to displace the prior state-law regime." U.S.Br.37-38. That writes §1395dd(f)'s preemption disclaimer out of the statute. EMTALA does not make an enemy of state law as the Government imagines.

By its own terms, EMTALA anticipates its "provisions … do not preempt" and thus will operate alongside state law. §1395dd(f); *accord* §1395. Myriad state healthcare laws will relate to EMTALA's provisions about stabilizing patients before they are transferred. Triggering §1395dd(f)'s exception requires far more: there must be "directly" conflicting state- and federal-law "requirement[s]."

The Government dismisses the use of "directly" in §1395dd(f) by subordinating text to legislative history and claiming there is nothing noteworthy about that modifier. *See* U.S.Br.36-37. Undermining the Government's claim that such limiting language appears "often," U.S.Br.37, such language is absent in other Medicare preemption provisions that the Government cites, U.S.Br.46. This Court "presume[s] that Congress acts intentionally" when using different language. *Bates v. United States*, 522 U.S. 23, 29-30 (1997). That choice cannot be "cloud[ed]" by legislative history. *Ratzlaf v. United States*, 510 U.S. 135, 147-

148 (1994).[2] EMTALA does not say it preserves only "'stricter' state laws." *Contra* U.S.Br.37. It preserves state-law requirements unless they "directly" conflict. §1395dd(f). The "limiting purpose of that language" must be given its full effect. *Bowsher v. Merck & Co.*, 460 U.S. 824, 839 (1983).

The Government also conflates "requirement" in §1395dd(f) with "the care EMTALA 'require[s]'"—by which the Government means what HHS might require. U.S.Br.32-36. Conceding EMTALA does not "set forth the specific treatments," the Government resorts to speculation that there might be a future case where HHS decides an abortion is required and Idaho decides it is (or is not) prohibited. U.S.Br.32-34. *But see* Leg.Br.28-30; Part III, *infra* (explaining care is not prohibited). That guesswork is not the stuff of a direct conflict. *See, e.g.*, *Rice v. Norman Williams Co.*, 458 U.S. 654, 659 (1982) ("a hypothetical or potential conflict is insufficient"). It cannot overcome §1395dd(f)'s default rule that EMTALA's provisions generally "do not preempt" state law. That default rule applies to EMTALA's definition of "stabilize," *contra* U.S.Br.33, just as it applies to other provisions.

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[2] The Government (U.S.Br.37) plucks five words from a committee report's discussion of EMTALA's penalty provision. *See* H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 4 (1985). That same report discussed possible penalties for "gross deviation from prevailing standards of *local medical practice*"—showing how EMTALA was understood to operate alongside state law. *Id.* at 28 (emphasis added). As with any legislative history, the Government can "look[] over a crowd and pick[] out [its] friends," and so can the Legislature. *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005).

Nor is there any basis to read EMTALA to give HHS a line-item veto over state healthcare laws. That inverts §1395dd(f) and contravenes the Medicare Act's proviso. "Nothing" in EMTALA "shall be construed to authorize" HHS or other federal officials "to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." §1395. But here, the Government contends §1395 is inapplicable, freeing HHS to demand not just "particular stabilizing treatments" but also prohibited treatments under state law. U.S.Br.29, 35-36. The Government has not carried its "heavy burden" to establish EMTALA impliedly repealed that proviso in such a dramatic way. *Epic Sys. Corp. v. Lewis*, 584 U.S. 497, 510 (2018); *see Morton v. Mancari*, 417 U.S. 535, 550 (1974) (requiring "irreconcilable" statutes). EMTALA has never been interpreted to allow HHS to set "a national minimum standard" of emergency care overriding state law concerning specific treatments. *Contra* U.S.Br.4, 35-39. In HHS's own words: "EMTALA does not … establish a national standard of care." 68 Fed. Reg. 53,222, 53,244 (Sept. 9, 2003); *accord* Part I.B.4, *infra*; *Harry v. Marchant*, 291 F.3d 767, 773 (11th Cir. 2002).

EMTALA is best read as *supplementing* state law by "get[ting] patients into the system" at the emergency room's front door. *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996). It filled a gap "by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all." *Hardy v. N.Y.C. Health & Hosps. Corp.*,

164 F.3d 789, 792-793 (2d Cir. 1999).[3] But it did not "displace the prior state-law regime." *Contra* U.S.Br.37-38. Section 1395dd(f) sends the opposite message: "EMTALA would peacefully coexist with applicable state 'requirements.'" *Hardy*, 164 F.3d at 795.

2. Contrary to the Government's assertions, U.S.Br.36, it is not "difficult to see what work" §1395dd(f) "would do" if read for what it says. That "work" is mainly to *disclaim* that EMTALA preempts state laws. The "work" of EMTALA more broadly is not to "establish a national standard of care," 68 Fed. Reg. at 53,244, but to provide a federal remedy for patient dumping, §1395dd(d). *See* Manhattan Inst. Br.3-7 (collecting cases). Section 1395dd(f)'s exception has been satisfied in cases involving state-law litigation requirements that frustrate that remedy. *See, e.g.*, *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 866 (4th Cir. 1994) (state law requiring presentation of claims to healthcare provider and submission to malpractice review panel); *Reid v. Indianapolis Osteopathic Med. Hosp., Inc.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989) (similar). It also has been satisfied where a state law allowed hospitals to summon peace officers to remove intoxicated patients from emergency rooms. *See Carlisle v. Frisbie Mem'l Hosp.*, 888 A.2d 405, 415 (N.H. 2005); *see also, e.g.*, *In re Baby "K,"* 16 F.3d 590, 597 (4th Cir. 1994) (concluding conscience law was preempted insofar as it allowed physicians to refuse

[3] Though hospitals traditionally had no common-law duty to treat, several States began recognizing a duty to provide emergency care in the years leading up to EMTALA. *See* Comment, *To Treat or Not to Treat: A Hospital's Duty to Provide Emergency Care*, 15 U.C. Davis L. Rev. 1047, 1048-1060 (1982).

to treat patient's condition while continuing to treat the same condition for others). But nothing about EMTALA's preemption provision or its limited stabilize-to-transfer rule suggests physicians must do as the Government suggests: offer treatments that could violate state law.

B. EMTALA does not require unlawful medical treatment.

The Government's preemption theory severs EMTALA's reference to "necessary stabilizing treatment" from the surrounding text. Putting those words back in context, EMTALA concerns *when* and *where* a patient's emergency medical condition is stabilized. But it does not directly conflict with state laws regulating *how* she can be stabilized. *See* Leg.Br.24-25. EMTALA leaves open what "such medical treatment" can be, §1395dd(e)(3)(A), and thus "do[es] not preempt any State or local law requirement" concerning such treatments, §1395dd(f). States may fill those gaps. *See* Indiana Br.8-9.

Instead of responding to that argument, the Government takes on a strawman. The Legislature never advanced a "nondiscrimination rule" limited to treatment of indigent patients. *Contra* U.S.Br.28-30. EMTALA forbids dumping any patient, irrespective of motive. *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 253 (1999) (per curiam). The preemption question here is distinct: In deciding whether a patient has been dumped, does EMTALA operate alongside state laws regulating available medical treatments or displace them?

None of EMTALA's terms, read in context, imposes a requirement to provide potentially unlawful medical treatments. Nor had HHS ever interpreted EMTALA to do so until *Dobbs*.

1. *"Result from or occur during the transfer."* The Government asserts "EMTALA mandates a general care objective: stabilization," U.S.Br.39, and sets "a national minimum standard" of emergency care, U.S.Br.4. EMTALA is not so sweeping. It does not require curing conditions. *See Green v. Touro Infirmary*, 992 F.2d 537, 539 (5th Cir. 1993). HHS guidance instructs that EMTALA's "[t]erms relating to 'stabilization' … DO NOT REFLECT the common usage in the medical profession."[4] Rather, to "stabilize" means providing "such medical treatment" for an emergency medical "condition." §1395dd(e)(3)(A). To what end? "[T]o assure, within reasonable medical probability, that no material deterioration of the condition is likely to *result from or occur during the transfer* … ." *Id.* (emphasis added). The requirement applies only to transfers. *Harry*, 291 F.3d at 775. It does not apply to admitted patients, 42 C.F.R. §489.24(d)(2)(i), or even every transfer, §1395dd(c)(1)(A).

The stabilize-to-transfer requirement thus concerns *when* and *where* a patient is stabilized, while leaving *how* to state law. Consider EMTALA's provisions specific to women in labor. She is "stabilized" once she "has delivered (including the placenta)."

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[4] CMS, *Quality Improvement Organization Manual*, Ch. 9, at 91 (Rev. 24, Issued Feb. 12, 2016), https://perma.cc/EYL8-MNHY (*QIO Manual*).

§1395dd(e)(3)(B). That definition sets a *temporal* limitation on when a hospital could send her to another hospital. But there is no EMTALA requirement dictating *how* the baby (or placenta) must be delivered. Leg.Br.25. EMTALA, for example, would not preempt state laws regulating VBACs or breech deliveries. *See, e.g.*, Okla. Admin. Code 310:395-5-6.1; Idaho Code §54-5505(e)(i)(5). So too for other emergency medical conditions. EMTALA operates alongside state law and leaves it to state malpractice law to decide whether medical treatment was negligent. *See, e.g.*, *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996) (Wilkinson, C.J.). HHS agrees, instructing physician reviewers that EMTALA is distinct from malpractice and "determining negligence is not part of and should not be mentioned in your EMTALA review."[5]

The Government fails to read "[n]ecessary stabilizing treatment," §1395dd(b), in "context and with a view to [its] place in the overall statutory scheme," *Gundy v. United States*, 139 S. Ct. 2116, 2126 (2019). It contends, without reference to transfers, that "when the treatment required to stabilize a pregnant woman's emergency medical condition is terminating the pregnancy, EMTALA requires … that treatment." U.S.Br.41. Elsewhere, the Government suggests "stabilizing" means providing abortions to *prevent* or *avoid* emergency conditions, versus stabilizing present conditions sufficiently for transfer. *E.g.*, U.S.Br.8 ("prevent grave harm"); U.S.Br.48 ("avoid grave harm"). That repeats the error in the district court's

[5] *QIO Manual* 89.

preliminary injunction.[6] That error infects the entire preemption analysis. Redefining EMTALA's stabilize-to-transfer requirement redefines EMTALA's preemptive scope.

2. *"Such treatment."* The Government misreads EMTALA's general references to "such treatment" and "such medical treatment," §1395dd(b)(1)(A), (e)(3)(A), to mean "specific treatments" that HHS endorses. U.S.Br.32-35. The Government observes that "such treatment" must mean "specific treatments" because hospitals cannot refuse treatments and then defend that failure to stabilize by asserting "EMTALA does not mention … specific treatments." U.S.Br.40. But that contemplates the wrong question. The question is not whether the hospital can refuse to provide blood transfusions, for example, because EMTALA does not say "blood transfusions." The question is whether the hospital can be commanded to take blood from the unconscious patient next door because EMTALA can override a State's criminal battery law or any other law. That is, whether EMTALA's general "treatment" references preempt state laws concerning *unlawful* medical treatments.

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[6] For this reason, the Government is wrong that the preliminary injunction would have "no practical effect" if Idaho law means what the Legislature says. U.S.Br.21. The Legislature had every reason to seek a stay of an order enjoining enforcement of state law for abortions performed merely "to avoid" emergency medical conditions, J.A.656, contorting EMTALA to say something it does not.

The Government says yes. It contends EMTALA requires treatments that might "violate state law" because EMTALA does not limit "such treatment" to *lawful* treatment under state law. U.S.Br.35-36. That again forgets §1395dd(f). If "EMTALA does not itself set forth the specific treatments," as the Government acknowledges, U.S.Br.32-33, then EMTALA does not preempt and thus operates alongside state laws delimiting lawful medical treatment. Part I.A, *supra*.

3. "*Unborn child.*" The Government's response regarding EMTALA's references to "unborn child" misstates the statute. U.S.Br.41. The Government says EMTALA's duties "run to the 'individual' seeking care," meaning the "pregnant woman." *Id.* But the statute describes stabilizing "the condition." §1395dd(e)(3). So "when a pregnant woman presents with an emergency condition that threatens her unborn child's health," the stabilization requirement runs *not* to "her," *contra* U.S.Br.42, but to her unborn child's "emergency medical condition," §1395dd(e)(1)(A)(i), (e)(3).

EMTALA's definitions thus contemplate "dual stabilization requirements" for both a pregnant woman and her unborn child. J.A.697-698. It would "too easily find irreconcilable conflicts in [Congress's] work," *Epic Sys.*, 584 U.S. at 511, to interpret EMTALA as simultaneously requiring life-saving medical treatment for an unborn child, §1395dd(e)(1)(A)(i), (e)(3), and life-ending abortions. Instead, EMTALA leaves it to state legislatures to choose how to strike that balance, including maximizing health outcomes for both mother

and child. *See Texas v. Becerra*, 89 F.4th 529, 544-545 (5th Cir. 2024).

4. *HHS.* With no abortion requirement in the text, the Government resorts to HHS practice. The Government asserts "HHS has long taken action" when hospitals fail to perform abortions. U.S.Br.16. But the Government identifies *no* instance where HHS instructed hospitals to provide unlawful medical treatments. Nor does it appear HHS ever understood EMTALA to require potentially unlawful abortions until *Dobbs*.[7]

Before *Dobbs*, HHS said "EMTALA does not … establish a national standard of care." 68 Fed. Reg. at 53,244. It said the "focus" of EMTALA's stabilize-to-transfer rule is "medical risks associated with a particular transfer/discharge."[8] That EMTALA rule might *add to* state-law requirements but does not *override* them. For example, the Government's cited guidance (U.S.Br.39) expects that States designate

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[7] HHS issued 2021 guidance in response to Texas's SB8 abortion law and after the Court granted certiorari in *Dobbs*. Former HHS Officials Br.15. It identified "ectopic pregnancy," miscarriage complications, and "severe" preeclampsia as pregnancy-related emergency conditions, and while it stated EMTALA "preempts any directly conflicting state law or mandate," it did not say EMTALA requires "abortion." CMS, *QSO-21-22-Hospitals* 1, 4 (Sept. 17, 2021), https://perma.cc/368R-4M7W. After *Dobbs*, President Biden asked HHS to "consider[] updates to current guidance." Exec. Order No. 14,076, 87 Fed. Reg. 42,053, 42,053 (July 8, 2022), Leg.App.27. Days later, CMS issued revised guidance identifying "abortion" as "stabilizing treatment" that "the physician **must** provide." *QSO-22-22-Hospitals*, Leg.App.33.

[8] *QIO Manual* 91.

certain hospitals for certain patients, such as psychiatric or women's hospitals.[9] It simply explains that if such a patient arrived at a Medicare-participating hospital's emergency room, the hospital must still screen and stabilize emergency conditions before transferring, unless EMTALA would allow transferring before stabilizing.[10] But the Government identifies no pre-*Dobbs* directive to perform unlawful procedures. HHS instead said "hospitals are required to be in compliance with Federal and State laws."[11] And Congress said Medicare-participating hospitals must comply with state-law licensing requirements and physicians must be "legally authorized to practice medicine and surgery by the State." §1395x(e)(7), (r).

As for the cited HHS enforcement actions, U.S.Br.16 n.2, all but two involve ectopic pregnancies—not abortion.[12] The other two involve failures to account for patients' symptoms before discharging them; neither required hospitals to perform abortions, let alone abortions that could violate state law.[13] Take the Government's first example, involving a Catholic hospital refusing to abort a 17 to 23–week unborn child with fetal heart tones. The hospital discharged

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[9] *See* CMS, *State Operations Manual*, App. V, at 40 (Rev. 191, July 19, 2019), https://perma.cc/89M6-Y2FP (*State Operations Manual*).

[10] *Id.* at 40, 61.

[11] CMS, *QSO-19-15-EMTALA* 3 (July 2, 2019), https://perma.cc/BD3P-G3ST.

[12] *See* CMS, *Hospital Surveys with 2567 Statement of Deficiencies – 2023Q4*, https://perma.cc/A3TN-8M67 (2010-2016 file, rows 3,732, 8,645, and 25,877; 2017-2023 file, rows 25,709 and 45,218).

[13] *Id.* (2010-2016 file, rows 16,963 and 20,800)

the patient for her to seek an abortion elsewhere, and HHS found the hospital's failure to "transfer[] via ambulance" compromised "the health of the *unborn baby* and the patient."[14]

Even if HHS had required abortions in past cases, that is not enough to declare Idaho law preempted for future cases. A court cannot determine, *ex ante*, when pregnancy termination is the "only medically appropriate stabilizing treatment" for future emergencies (U.S.Br.34) and declare a direct conflict. *See Norman Williams*, 458 U.S. at 659. HHS evaluates EMTALA violations retrospectively based on case-specific circumstances.[15] It asks whether "[t]he stabilizing treatment was appropriate within a hospital's capability," not what the "clinical outcome" was.[16] Likewise, Idaho law turns on physicians' subjective, good-faith judgments and facts known at the time. *See Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1203 (Idaho 2023). Medical judgments will be case-specific. When, for example, a pregnant woman experiences PPROM, even ACOG recognizes that "expectant management" is sometimes the standard of care to determine whether mother and child can remain stable until viability for a preterm delivery.[17] Other times, pregnancy termination is necessary and permitted. J.A.545-546, 571; *see* Leg.Br.29-30. Where there is no one-size-fits-all treatment for emergency conditions,

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[14] *Id.* (emphasis added) (2010-2016 file, row 16,963).

[15] *State Operations Manual* 14.

[16] *Id.*

[17] *See* ACOG, *Practice Bulletin No. 217, Prelabor Rupture of Membranes*, 135 Obstetrics & Gynecology e80 (2020), https://perma.cc/EXJ5-M9TB; *accord* Charlotte Lozier Br.11, 14; AAPLOG Br.9-10.

there is no basis for declaring a direct conflict under EMTALA.

C. The Government's contrary view has no limiting principle.

The Government's incantations of "narrow" and "rare" are no limiting principle. U.S.Br.16, 25, 50. The Government concedes EMTALA "does not itself set forth the specific treatments." U.S.Br.32-33. That leaves HHS to decide and, by the Government's logic, to preempt based on evolving "clinical standards." U.S.Br.33-34, 47. Below, the Government was more direct, claiming EMTALA requires "*any* form of stabilizing treatment, if the relevant medical professionals determine that such care is necessary" regardless of state law. Gov't C.A.Br.15 (Sept. 8, 2023).

The Government's view would have enormous consequences for States. *See* Manhattan Inst.Br.7-9; Indiana Br.6-7. For example, HHS guidance lists "suicidal ideation" as an "emergency medical condition."[18] A future HHS could decide abortions are the only stabilizing treatment for severe pregnancy-related depression, displacing state and federal laws with abortion exceptions for only "physical" conditions. *E.g.*, Consolidated Appropriations Act, Pub. L. 117-328, §507(a)(2), 136 Stat. 4908 (2022); 18 U.S.C. §1531(a); Idaho Code §18-622(2)(a)(i) (excluding self-harm). The Government's preemption theory also extends beyond abortion laws to any other conceivable treatments for physical or psychiatric emergency medical condi-

[18] *State Operations Manual* 10.

tions—be it restrictions on live organ donation, abortion pill reversal and other drug restrictions, or bans on "gender-affirming" care or conversion therapy for minors. *See, e.g.*, Idaho Code §39-3401 *et seq*. (regulating organ donation); Colo. Rev. Stat. §12-30-120(2)(a) (prohibiting "medication abortion reversal"); Ala. Code §26-26-4(a) (prohibiting "puberty blocking medication"); Wash. Rev. Code §18.130.180(26) (banning "conversion therapy").

EMTALA says the opposite. Its provisions do not preempt state laws absent a direct conflict. §1395dd(f). What's more, §1395 condemns reading EMTALA to give federal officials "supervision or control over … the manner in which medical services are provided." EMTALA's general provisions about providing "such treatment" for emergency medical conditions before transferring patients cannot be read to require hospitals to provide unlawful treatments.

II. The Government Ignores Federal Laws Expressly Regulating Abortion.

A. When Congress expressly legislates about abortion, Congress draws the same lines as Idaho, generally prohibiting certain abortions or funding except when necessary for life-threatening physical conditions or in cases of rape or incest. Leg.Br.31-34; *see* Part III, *infra*. That "is surely evidence that Congress does not view" Idaho law "as incompatible" with EMTALA. *De Veau*, 363 U.S. at 156 (plurality op.). But

the Government would instead read EMTALA to require abortions that Congress won't pay for and potentially those it prohibits. *See* U.S.Br.45.[19]

The Government contends those other federal laws "explicitly" address abortion because they are "excluding abortion care," whereas EMTALA's silence must be read as imposing an "abortion care" requirement. U.S.Br.40. EMTALA cannot be so construed without ignoring Congress's longstanding neutrality on abortion. Leg.Br.31-34. Nor would that be consistent with EMTALA's preemption disclaimer in §1395dd(f). Part I.A, *supra*. Any "reasonable interpreter" familiar with those laws "would expect [Congress] to make th[ose] big-time policy calls itself" in EMTALA. *Biden v. Nebraska*, 143 S. Ct. 2355, 2380 (2023) (Barrett, J., concurring).

B. The Government's sweeping view of EMTALA also runs headlong into federal conscience protections without any answers for reconciling them. Leg.Br.34; *see* 42 U.S.C. §§238n(a), 300a-7(d), 300a-8; *accord* CMDA Br.17-23, USCCB Br.15-21. If EMTALA is so particularized that it commands "specific treatments" including "immediate" abortion, U.S.Br.15, 34, how will HHS treat the Catholic hospital or the lone obstetrician in a rural emergency room with conscience objections?

The Government has disclaimed that EMTALA requires abortions over conscience objections because

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[19] Citing nothing, the Government declares that "there is no emergency medical condition that can only be stabilized by" partial-birth abortions. U.S.Br.45 n.10. The Government does not address the Comstock Act, 18 U.S.C. §1461. *See* Leg.Br.32.

EMTALA imposes obligations on hospitals, "not individual doctors." Gov't Br. 23 n.3, *FDA v. All. for Hippocratic Med.*, No. 23-235 (U.S. Jan. 23, 2024); *see* U.S.Br.17. But HHS enforces EMTALA against "any physician" too. §1395dd(d)(1)(B); *see, e.g.*, *Burditt v. HHS*, 934 F.2d 1362 (5th Cir. 1991); *see also Baby "K,"* 16 F.3d at 597 (rejecting conscience objection given EMTALA's application "to treating physicians"). And conscience laws protect *both* hospitals and physicians. *E.g.*, §238n(a). The Government cannot contend here that EMTALA contains treatment requirements so specific that they displace state healthcare laws and simultaneously contend that EMTALA's provisions are too "general" to "override specific statutory conscience protections" in *Hippocratic Medicine*. Gov't Reply Br. 6 (Mar. 15, 2024).[20]

C. The Government contends that an Affordable Care Act provision that refers to "emergency services as required by … 'EMTALA,'" §18023(d), means "abortion" because preceding subsections expressly refer to abortion. *See* U.S.Br.19-20. But the preceding subsections reflect Congress's neutrality on abortion—barring federal funds for abortion, §18023(b)(2), disclaiming preemption of state abortion laws, §18023(c)(1), and reaffirming federal conscience protections, §18023(c)(2). President Obama's contemporaneous executive order confirms that the ACA "maintains current Hyde Amendment restrictions" and that

[20] In *Hippocratic Medicine*, the Government also claimed it is "not aware" of any "direct conflict between EMTALA and conscience protections." O.A.Tr.19 (Mar. 26, 2024). But here, the Government's enforcement examples lead with a conscience-related violation involving a Catholic hospital. *See* pp.13-14, *supra*.

longstanding federal conscience protections "remain intact." Exec. Order No. 13,535, 75 Fed. Reg. 15,599, 15,599 (Mar. 24, 2010). There is no basis for reading §18023(d)'s reference to EMTALA, or EMTALA itself, to silently override Congress's longstanding neutrality on abortion policy. Congress has deferred to the States to enact their own abortion laws. EMTALA does not preempt those legislative judgments.

III. The Government Contrives a Conflict by Misstating Idaho Law.

Even accepting the Government's sweeping view of EMTALA, nothing in Idaho's Defense of Life Act "prohibit[s] the very care EMTALA requires." *Contra* U.S.Br.37. If the Government were right that EMTALA requires non-life-saving abortions that Idaho prohibits, then EMTALA requires something that Congress also prohibits paying for—perplexing, given EMTALA is a spending condition. *See* Leg.Br.31-34. The Government is not right. State and federal law are harmonious. There is no direct conflict between a physician's duties under EMTALA and Idaho law, which expressly anticipates and allows life-saving medical treatment. Leg.Br.8-10, 12-14. The Government has not identified any emergency condition that an Idaho physician could not treat. Leg.Br.29-30. It cannot now invent a conflict by ignoring the Idaho Supreme Court's binding interpretation of Idaho law. *See R.A.V. v. City of St. Paul*, 505 U.S. 377, 381 (1992).

A. Idaho prohibits criminal abortions. "Medical treatment … that results in the accidental death of, or unintentional injury to, the unborn child" is not such an abortion under Idaho Code §18-622(4)—a provision

the Government never acknowledges. Medical treatments for ectopic or molar pregnancies, incomplete miscarriages, and other nonviable pregnancies are not abortions under §18-604(1) and (11)—provisions the Government ignores by conflating abortion with treating ectopic pregnancies or other nonviable pregnancies (U.S.Br.16 n.2, 43). Beyond those non-abortions, intentional pregnancy termination is permitted when "necessary to prevent the death of the pregnant woman" while "provid[ing] the best opportunity for the unborn child to survive." §18-622(2)(a)(i)-(ii); *see Planned Parenthood*, 522 P.3d at 1203-1205. That exception follows the longstanding "two-patient paradigm." Charlotte Lozier Br.4-5, 7, 11-12. Necessary medical treatment may entail separating the mother and unborn child, but the intent is protecting the mother's life, not ending the unborn child's. *E.g.*, J.A.571-572; *accord* AAPLOG Br.6-7; 121 Congressmembers Br.12-13. Idaho law "leave[s] wide room" for physicians' "good faith medical judgment" to decide when that life-saving treatment is warranted. *Planned Parenthood*, 522 P.3d at 1203.

B. The Government cabins its theory about when Idaho law conflicts with EMTALA. It no longer contends that there is a conflict *whenever* any physician thinks abortion is necessary. U.S.Br.34. Now, the supposed conflict is "before viability" when "pregnancy termination … is the *only* medically appropriate stabilizing treatment" per "clinical standards." U.S.Br.26, 34 (emphasis added). The Government acknowledges that such emergency pregnancy conditions will become "life-threatening" and recasts its ar-

guments to be about "delaying" care for those conditions. U.S.Br.23-25. What remains of that theory impermissibly ignores both the record and the Idaho Supreme Court's construction of Idaho law.

1. Contrary to the Government's speculation, Idaho permits necessary medical treatment for every proffered pregnancy-related condition. The Government contends that Idaho's necessary-to-prevent-death exception is too narrow because EMTALA requires abortions for "health" and not only "death." U.S.Br.22. But the Government's declarants identified no such "health" condition for which abortion is the "only care" (U.S.Br.21) under the Government's test. *See* Leg.Br.12-14, 29-30. The Government now acknowledges that the conditions its declarants identified that could require pregnancy termination are conditions that will ultimately threaten "her life." U.S.Br.20. The Government's quibbling about when such conditions become life-threatening does not create a direct conflict. The Legislature's qualified physicians testified that they considered every condition life-threatening and would treat them without hesitation. Leg.Br.12-14, 29-30.[21] Those physicians' good-faith, subjective views control under Idaho law. *Planned Parenthood*, 522 P.3d at 1203.

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[21] *See* J.A.546-547, 571-572 (PPROM and related complications); J.A.547, 569, 572-573 (placental abruption and related complications); J.A.547, 573-574, 576-578, 581-582 (preeclampsia and HELLP syndrome); J.A.563-564, 570, 575, 579, 582-583 (other necessary "medical treatment"); *accord* AAPLOG Br.9-12; Charlotte Lozier Br.4, 11-15; Stanton Int'l Br.5-6.

2. Nor must Idaho physicians "delay" treatment in ways that conflict with EMTALA. *Contra* U.S.Br.22-25. The Idaho Supreme Court has rejected the same delay arguments. In Idaho, there is *no* "level of immediacy" required for an abortion to be necessary life-saving treatment. *Planned Parenthood*, 522 P.3d at 1203. The statute does not require "*objective* certainty" that the condition will cause death. *Id.* at 1203-1204 (no "'certain percent chance' requirement").

The Government cannot disregard, with rhetoric or anecdotes, that binding interpretation of Idaho law. *See R.A.V.*, 505 U.S. at 381. The statute's meaning is not merely "cold comfort." *Contra* U.S.Br.25. A physician who inexcusably delays care invites a medical malpractice action, professional discipline, or other repercussions. *See, e.g.*, *Dunlap v. Garner*, 903 P.2d 1296 (Idaho 1994); *Kozlowski v. Rush*, 828 P.2d 854 Idaho 1992); *Woodfield v. Bd. of Pro. Discipline of Idaho State Bd. of Med.*, 905 P.2d 1047 (Idaho App. 1995) (affirming in part extensive disciplinary findings against OB/GYN). Tragic anecdotal accounts of delayed care are not a basis for declaring Idaho law preempted but could be a basis for a "malpractice" claim, as the Legislature's witness testified. J.A.546.

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EMTALA operates alongside state healthcare laws absent a direct conflict. Under either the longstanding interpretation of EMTALA or the Government's rewrite, Idaho's Defense of Life Act presents no direct conflict.

IV. The Government's Preemption Theory Exceeds the Limits of Executive Power at the Expense of Idaho's Sovereignty.

A. The Government's preemption theory offends the major questions doctrine. Leg.Br.38-48. It fits the pattern of recent rejections of newfound executive power "beyond what Congress could reasonably be understood to have granted." *West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (2022). Billions in Medicare funding is at stake if hospitals do not offer abortions or other unlawful treatment that HHS deems necessary today or in the future. *See* Leg.Br.40-41. That Congress would silently "delegate a policy decision of such … magnitude" regarding state abortion and healthcare laws to HHS defies "common sense." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000).

1. The Government's assertions that "this is not an agency-delegation case" and involves only the "straightforward application" of EMTALA (U.S.Br.49, 51) are belied by its arguments. The linchpin of the Government's case is HHS and its decision-making authority about what treatments EMTALA requires and thus preempts. U.S.Br.32-34. The major questions doctrine applies to that power-grab just as it applies to others in the Executive Branch. *See, e.g.*, *Ala. Ass'n of Realtors v. HHS*, 141 S. Ct. 2485, 2489 (2021) (per curiam) (CDC); *Nebraska*, 143 S. Ct. at 2374 (Education Secretary).

That the Government is pursuing its newfound preemption power through litigation before regulation makes no difference. *See* Leg.Br.41-42; *see also, e.g.*,

Nebraska, 143 S. Ct. at 2374-2375 (rejecting Government's argument that major questions doctrine concerns only agency's "power to regulate" versus "provision of government benefits"). No executive official has any "power to act, let alone pre-empt the validly enacted legislation of a sovereign State, unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). The Executive Branch cannot circumvent that principle by skipping required rulemaking, §1395hh(a)(2), disregarding EMTALA's enforcement mechanism, §1395dd(d), and initiating this unprecedented suit against Idaho.

2. Nor is the Government simply enforcing Congress's "policy decisions." U.S.Br.49. There is no abortion requirement hiding in EMTALA. Part I.A, *supra*; *see Gonzales*, 546 U.S. at 267. Finding one is not "the text's most natural interpretation." *Nebraska*, 143 S. Ct. at 2376 (Barrett, J., concurring). It requires reading terms like "such treatment," §1395dd(b)(1)(A), to be "shorn of all context" and to empower HHS to require something "Congress ha[s] conspicuously and repeatedly declined to enact itself." *West Virginia*, 142 S. Ct. at 2610; Part II, *supra*.

It is the Government that attempts to "retroactively change EMTALA's meaning" and disrupt "long-settled understandings." U.S.Br.50-51. Preempting validly enacted state laws requires "clear congressional authorization" that the Government nowhere identifies. *Utility Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014). There is no unstated abortion exception allowing Congress to speak any less clearly here. *Contra* U.S.Br.50 (contending Congress "had no reason to speak more 'clear[ly]'" during *Roe*).

B. The Government's preemption theory would also unleash federal spending power. Idaho never accepted EMTALA's supposed abortion requirement, and Congress generally won't pay for it. Leg.Br.48-51; U.S.Br.45. Most Medicare enrollees are beyond childbearing age.[22] For the few who aren't, Congress pays only for life-saving treatment, mirroring Idaho law. Leg.Br.33-34. Still, the Government insists that EMTALA and any future Spending Clause conditions are entitled "full preemptive force" with or without States' acceptance. U.S.Br.45. By that logic, the Government could create new Medicare conditions requiring private hospitals to offer elective abortions, euthanasia, or any medical treatment banned by States. *See* U.S.Br.47 (asserting state laws conflicting with spending conditions "pose an 'obstacle to the … purposes and objectives of Congress'").

Precedent does not support a Spending Clause so unbounded. *See* Leg.Br.48-51; St. Thomas Br.2-18. The Government's and *amici*'s cited authorities show that the Spending Clause might preempt state laws modifying eligibility criteria for federal benefits, *e.g.*, *Townsend v. Swank*, 404 U.S. 282, 283-285 (1971), or interfering with federal funds directly, *e.g.*, *Bennett v. Arkansas*, 485 U.S. 395, 396 (1988) (per curiam); *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 258-259 (1985). Likewise, the Government's cited Medicare statutes regarding Medicare Advantage and prescription plans (U.S.Br.46) prevent States from interfering with eligibility standards and operational requirements, like licensure. *E.g.*,

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[22] *An Overview of Medicare*, KFF (Feb. 13, 2019), https://perma.cc/B4LD-CQUQ.

§1395w-25(a)(1)-(2). But here, the Government concedes its abortion condition has nothing to do with Medicare's funding, eligibility requirements, enrollees, or funded treatments. U.S.Br.45. The condition is a moving target that States never accepted, nor could accept. *See* Leg.Br.51-53; *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

C. The Government can hardly maintain there is "no Tenth Amendment violation" (U.S.Br.47) if there is no statutory or constitutional basis for its preemption theory. The Government cannot explain away the consequences of its preemption theory with a breezy reference to "the classic model of preemption." U.S.Br.47. *Gonzales* does the Government no favors. *Contra* U.S.Br.47 *Gonzales* rejected "expansive federal authority" over healthcare, observing "the background principles of our federal system also belie the notion that Congress would use such an obscure grant of authority" to displace Oregon's assisted suicide law. 546 U.S. at 273-274. The same rules apply here. The Government has not shouldered its burden to identify "exceedingly clear language" in EMTALA displacing States' historic police powers. *Sackett v. EPA*, 143 S. Ct. 1322, 1341 (2023); *see Rice*, 331 U.S. at 230. Merely "pointing to the Supremacy Clause will not do." *Murphy v. NCAA*, 584 U.S. 453, 477 (2018).

EMTALA must be read for what it says and no more. It supplements state laws, opening emergency rooms to all patients; it is not an abortion access statute. It inverts our federalist system to construe EMTALA to preempt validly enacted state abortion laws. *Dobbs* "return[ed] the issue of abortion to the people's elected representatives." *Dobbs v. Jackson Women's*

Health Org., 142 S. Ct. 2228, 2243 (2022). The people are once again "engaged in an earnest and profound debate" about its "morality" and "legality." *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997). And their "state legislatures have acted accordingly." *Dobbs*, 142 S. Ct. at 2242. EMTALA does not preempt Idaho's validly enacted law. Idaho remains free to govern itself with respect to abortion.

CONCLUSION

The Ninth Circuit's order should be reversed and the preliminary injunction vacated.

Respectfully submitted,

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