NO. 23-727

IN THE

Supreme Court of the United States

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR THE PETITIONER

JOHN J. BURSCH
ERIN M. HAWLEY
MATTHEW S. BOWMAN
LINCOLN DAVIS WILSON
JACOB P. WARNER
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001

JAMES A. CAMPBELL
JULIE MARIE BLAKE
RORY GRAY
ALLIANCE DEFENDING FREEDOM
44180 Riverside Pkwy
Lansdowne, VA 20176

RAÚL R. LABRADOR
ATTORNEY GENERAL
ALAN M. HURST
SOLICITOR GENERAL
JOSHUA N. TURNER
Counsel of Record
JAMES E.M. CRAIG
700 W Jefferson St #210
Boise, ID 83720
josh.turner@ag.idaho.gov
(208) 332-3548

CHARLES J. COOPER
DAVID H. THOMPSON
PETER A. PATTERSON
MEGAN M. WOLD
COOPER & KIRK PLLC
1523 New Hampshire NW
Washington, DC 20036

Counsel for Petitioner

QUESTION PRESENTED

Whether the Emergency Medical Treatment and Active Labor Act (EMTALA) preempts state abortion regulations and requires hospitals to perform abortions disallowed by state law.

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE

Petitioner is the State of Idaho. Respondent is the United States of America. Mike Moyle, Speaker of the Idaho House of Representatives; Chuck Winder, President Pro Tempore of the Idaho Senate; and The Sixty-Seventh Idaho Legislature were proposed intervenors and appellants below and are petitioners in the consolidated case, No. 23-726.

LIST OF ALL PROCEEDINGS

U.S. Court of Appeals for the Ninth Circuit, Nos. 23-35440, 23-35450, *United States of America* v. *State of Idaho* and *United States of America* v. *Mike Moyle et al.*, en banc order entered November 13, 2023, reprinted at J.A.710–11.

U.S. Court of Appeals for the Ninth Circuit, Nos. 23-35440, 23-35450, *United States of America* v. *State of Idaho* and *United States of America* v. *Mike Moyle et al.*, order entered September 28, 2023, and corrected October 2, 2023, reprinted at J.A.690–708.

U.S. District Court for the District of Idaho, No. 1:22-cv-00329-BLW, *United States of America* v. *State of Idaho*, order entered August 24, 2022, reprinted at J.A.620–56.

U.S. Court of Appeals for the Ninth Circuit, No. 23-35153, *United States of America* v. *Idaho*, oral argument on the Idaho legislature's intervention request scheduled for April 4, 2024; legislature's motion to adjourn argument denied.

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STATEMENT OF JURISDICTION

The United States filed its complaint on August 2, 2022, invoking jurisdiction under 28 U.S.C. 1331 and 1345. The United States moved for a preliminary injunction that the district court granted on August 24, 2022. On May 4, 2023, the district court denied timely motions for reconsideration filed by Idaho and the Idaho legislature. Idaho and the legislature filed timely notices of appeal on June 28 and July 3, 2023, respectively, and a stay of the injunction pending appeal was sought.

A Ninth Circuit panel issued a published opinion granting a stay of the injunction pending appeal on September 28, 2023. The United States moved for emergency reconsideration en banc on September 30, 2023, which the Ninth Circuit granted in an unreasoned order on October 10, 2023. The en banc Ninth Circuit then denied the motion to stay pending appeal on November 13, 2023.

On November 20, 2023, Idaho and the legislature filed emergency applications for a stay with this Court, invoking 28 U.S.C. 1254(1) and 2101(f) and Supreme Court Rule 23.3. Idaho also asked the Court to treat its application as a petition for writ of certiorari before judgment.

On January 5, 2024, the Court granted the applications and stayed the district court's injunction. It also treated both applications as petitions for writ of certiorari before judgment, granted the petitions on the question presented in Idaho's application, and consolidated the cases for oral argument. The Court's jurisdiction rests on 28 U.S.C. 1254(1) and 28 U.S.C. 2101(e).

PERTINENT STATUTE

The federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd, is reprinted in full at J.A.712–22.

INTRODUCTION

In 1890, the people of the State of Idaho established a government and a constitution to secure the blessings of liberty and to promote the common welfare. Idaho Const., *Preamble*. Their new government recognized that all persons are by nature free and equal, and man-made laws exist to defend life and liberty. *Id.* art. I, § 1. Consistent with those principles, the people of Idaho have unwaveringly acted to protect the life and liberty of unborn children. Ending an unborn life except to save the mother's life has always been viewed in Idaho "as an immoral act and treated as a crime." *Planned Parenthood Great Nw.* v. *State*, 522 P.3d 1132, 1148 (Idaho 2023). Idaho's 150 years of protecting life is a heritage broken only by *Roe* v. *Wade*. But even during those 50 years when its hands were unconstitutionally tied, Idaho continued to defend unborn children. It passed laws regulating abortion to the extent federal courts would allow under *Roe,* and it enacted trigger laws that would reimplement Idaho's prior prohibitions against abortion "[i]n the event that the states are again permitted to safeguard the lives of unborn infants before the twenty-fifth week of pregnancy." See 1973 Idaho Sess. Laws 442, 448; see also Idaho Code § 18-613 (1979).

That anticipated day was finally realized when this Court overruled *Roe* and "return[ed] the issue of abortion to the people's elected representatives." *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 232 (2022). States were no longer subject to the "exercise of raw judicial power" that had overridden their laws and forced them to permit abortions. *Id.* at 261. And in Idaho, *Dobbs* triggered enforcement of the State's Defense of Life Act, Idaho Code § 18-622.

Two weeks after *Dobbs*, the Biden administration reinterpreted the Emergency Medical Treatment and Active Labor Act (EMTALA) to create a nationwide abortion mandate in hospital emergency rooms that accept Medicare funding. That mandate—discovered nearly 40 years after EMTALA's enactment—has no support in the statutory text. The mandate was an attempt to reimpose a federal abortion requirement, this time through the exercise of raw executive power. But EMTALA merely prohibits emergency rooms from turning away indigent patients with serious medical conditions. Rejecting the identical arguments advanced here, the Fifth Circuit recently held that "EMTALA does not mandate any specific type of medical treatment, let alone abortion." *Texas* v. *Becerra*, 89 F.4th 529, 542 (5th Cir. 2024).

In addition to requiring equal treatment of patients generally, EMTALA explicitly promises in four places *protection* for an "unborn child." That admonition belies any requirement that hospitals must end the lives of unborn children in violation of state law. In fact, EMTALA and Idaho's Defense of Life Act share a common goal—protecting unborn children. As the Fifth Circuit put it, "[t]he text speaks for itself: EMTALA requires hospitals to stabilize both the pregnant woman and her unborn child." *Texas*, 89 F.4th at 544.

According to the administration, EMTALA's protection for the unborn nullifies more than 20 states' pro-life laws, forcing doctors to abort unborn children in violation of state law. The United States' view also means that EMTALA preempts countless other state laws, such as those restricting experimental medication and procedures. That position is untenable given EMTALA's text and the clarity

required to preempt state law, especially in a Spending Clause context involving a major political question as significant as overriding state medical standards on abortion.

The administration's position—EMTALA conditions hospitals' Medicare participation on performing abortions a state deems unlawful—also attributes deep incoherence to Congress. The Hyde Amendment generally prohibits hospitals from using federal funds to pay for abortions, and the Hyde-Weldon Amendment prevents the Department of Health and Human Services (HHS) from using federal funds to require a healthcare entity to facilitate abortion. It is nonsensical to assume that Congress required the very thing it prohibits using federal dollars to fund. The district court's judgment should be reversed.

STATEMENT OF THE CASE

I. Idaho protects the lives of women and unborn children.

The people of Idaho recognize that the "life of each human being begins at fertilization, and preborn children have interests in life, health, and well-being that should be protected." Idaho Code § 18-8802(1). That statutory finding governs all of Idaho law. And it is consistent with over 150 years of Idaho policy that abortion should generally be allowed only if necessary to preserve the mother's life. *Planned Parenthood Great Nw.*, 522 P.3d at 1149–50 (citing Act of Feb. 4, 1864, ch. IV, § 42, 1863-64 Idaho Terr. Sess. Laws 443; Act of Dec. 23, 1864, ch. III, § 42, 1864 Idaho Terr. Sess. Laws 305; Act of Jan. 14, 1875, ch. IV, § 42, 1874-75 Idaho Terr. Sess. Laws 328; Idaho Rev. Stat. §§ 6794, 6795 (1887)).

Consistent with this statutory finding, in 2020, Idaho enacted a statute now known as the Defense of Life Act, which prohibits most abortions with exceptions for rape or incest. Idaho Code § 18-622. That Act became effective after this Court's *Dobbs* decision restored to the states the authority to regulate abortion. 597 U.S. at 292; 2020 Idaho Sess. Laws 827. As originally enacted, the Act created an affirmative defense for a physician performing an abortion where the "abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(i)–(iii) (2020).

After the district court entered the preliminary injunction at issue here, the Idaho Supreme Court issued its interpretation of the Defense of Life Act, which it upheld against a state-law challenge. *Planned Parenthood Great Nw.*, 522 P.3d at 1203. The Idaho Supreme Court clarified that removing an ectopic pregnancy is not an abortion under the Act, that the Act does not require "certainty" of physicians, and that the Act allows physicians to rely on good-faith medical judgment where necessary to save a mother's life. *Id.* at 1202–03.

The Idaho legislature then amended the Act to codify the Idaho Supreme Court's clarification on ectopic pregnancies and to recharacterize the Act's life-saving language as an exception to the Act's abortion prohibition rather than an affirmative defense. Idaho Code § 18-622 (2023).

II. EMTALA protects indigent patients and unborn children.

Congress enacted and President Reagan signed EMTALA into law nearly 40 years ago as part of the Medicare Act. The law addressed a specific concern: "that hospitals were dumping patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients' conditions stabilized." *Jackson* v. *E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001) (citing H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S.C.C.A.N. 579, 605). For that reason, the Act is "commonly known as the 'Patient Anti-Dumping Act.'" *Ibid.*; *Marshall ex rel. Marshall* v. *E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) (emergency rooms were "refusing to treat patients who are unable to pay").

Consistent with that purpose, EMTALA requires hospitals that accept Medicare to "provide" "any individual" who asks for examination or treatment "an appropriate medical screening examination within the capability of the hospital's emergency department … to determine whether" the individual has an "emergency medical condition." 42 U.S.C. 1395dd(a).

EMTALA defines "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

> (i) 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;
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part[.]"

42 U.S.C. 1395dd(e)(1)(A) (emphasis added). Congress thus specifically protected the "unborn child." And in the case of a pregnant woman in labor, an "emergency medical condition" also includes situations in which a transfer of the pregnant woman "may pose a threat to the health or safety of the woman *or the unborn child*." 42 U.S.C. 1395dd(e)(1)(B)(ii) (emphasis added).

Recognizing limits from hospital competencies and state-law requirements, EMTALA restricts a hospital's treatment obligation to those treatments available at the hospital. If a hospital determines that a patient has an emergency medical condition, it has two options: (1) provide, "within the staff and facilities *available at the hospital*, for such further medical examination and such treatment as may be required to stabilize the medical condition," or (2) "transfer … the individual to another medical facility." 42 U.S.C. 1395dd(b)(1) (emphasis added). To "stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. 1395dd(e)(3)(A).

Transfers under EMTALA must also ensure the protection of unborn children. Transfers cannot occur without a physician certifying expected benefits to

"the individual and, in the case of labor, *to the unborn child*," and transfers are not "appropriate" unless they "minimize[ ] the risks to the individual's health and, in the case of a woman in labor, the health *of the unborn child*." 42 U.S.C. 1395dd(c)(1)(A)(ii), (c)(2)(A).

For its entire history, courts have construed EMTALA consistent with its statutory purpose. As discussed below, every court of appeals to address the issue—including the Ninth Circuit—has correctly read EMTALA as an anti-dumping statute, not a statute dictating any particular "standard of care." *Bryant* v. *Adventist Health System/West*, 289 F.3d 1162, 1166 (9th Cir. 2002). "[T]here is no question" that EMTALA "does not require an 'appropriate' stabilization." *Roberts* v. *Galen of Va., Inc.*, 525 U.S. 249, 253 (1999) (per curiam). It requires only the care "available" at the hospital. 42 U.S.C. 1395dd(b)(1).

In sum, EMTALA leaves the question of specific treatments for stabilizing care to state law. And all women in labor—regardless of their ability to pay—can expect that their unborn children will be safely delivered. Indeed, EMTALA treats medical emergencies faced by "the unborn child" of a pregnant woman no differently than emergencies faced by the mother herself. 42 U.S.C. 1395dd(e)(1)(A).

Penalties for violating EMTALA are severe. A Medicare-participating hospital or physician "that negligently violates" EMTALA "is subject to a civil money penalty" up to $50,000 per violation. 42 U.S.C. 1395dd(d)(1)(A), (B). And if doctors violate EMTALA in a way that is more than negligent, they are "subject to … exclusion from participation in [Medicare] and State health care programs," including Medicaid and other programs. 42 U.S.C. 1395dd(d)(1)(B).

III. EMTALA defers to state-law medical standards.

States license and regulate medical providers "under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 475 (1996) (citation omitted). That is just as true for abortion, Idaho Code § 18-622, as it is for psychosurgery and electroconvulsive treatments, Idaho Code § 16-2423, and opioid and other pharmaceutical prescriptions, Idaho Code § 37-2705, to name a few examples. States retain the authority to protect the integrity and ethics of the medical profession. *Washington* v. *Glucksberg*, 521 U.S. 702, 731 (1997). That has always been the case "given the structure and limitations of federalism." *Gonzales* v. *Oregon*, 546 U.S. 243, 270 (2006). EMTALA operates against that backdrop of state regulation.

EMTALA does not preempt state laws regulating the practice of medicine for numerous reasons. First, any preemption analysis starts with the "assumption that the historical police powers of the States"—including their power to impose medical standards of care—do not yield to federal law apart from "the clear and manifest purpose of Congress." *Medtronic*, 518 U.S. at 485 (quoting *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Courts must construe statutes narrowly due to "the presumption against the pre-emption of state police power regulations." *Cipollone* v. *Liggett Grp., Inc.*, 505 U.S. 504, 518 (1992).

Second, the Medicare Act contains a savings clause clarifying that EMTALA does not override state regulation of medicine: "[n]othing in this subchapter"—which includes EMTALA—"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." 42 U.S.C. 1395.

Third, EMTALA provides a second savings clause affirming that it does "not preempt any State or local law requirement, except to the extent that the requirement *directly conflicts* with a requirement of this section." 42 U.S.C. 1395dd(f) (emphasis added).

Finally, EMTALA is Spending Clause legislation, and courts will read Congress's intent to have imposed "a condition on the grant of federal moneys" only if Congress did so "unambiguously." *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981).

All of this means—as the Ninth Circuit used to recognize—that EMTALA's "preemptive effect" must be construed "as narrowly as possible." *Draper* v. *Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (per curiam) (citation omitted).

IV. The administration reinterprets EMTALA as an abortion mandate.

In *Dobbs*, this Court returned the abortion issue to the states. 597 U.S. at 292, 302. Idaho law thus governs the regulation of abortion in Idaho. See *id.* at 302.

President Biden immediately decried *Dobbs* while nonetheless initially recognizing that the people—not his administration—now have "the final word" on the subject. The White House, *Remarks by President Biden on the Supreme Court Decision to Overturn Roe v. Wade* (June 24, 2022). That position lasted all of two weeks. The President then issued an executive order directing multiple agencies—including HHS, the Department of Justice, the Secretary of Homeland Security, and the Federal Trade Commission—to undertake a government-wide effort to use federal law to "promote" abortion. Protecting Access to Reproductive Healthcare Services, Exec. Order No. 14076, 87 Fed. Reg. 42053, 42053–54 (July 8, 2022). See also The White House, FACT SHEET: President Biden to Sign Executive Order Protecting Access to Reproductive Health Care Services (July 8, 2022), https://perma.cc/NHE6-D5J9; Securing Access to Reproductive and Other Healthcare Services, Exec. Order No. 14079, 87 Fed. Reg. 49505 (Aug. 3, 2022); Further Efforts To Protect Access to Reproductive Healthcare Services, Presidential Memorandum, 88 Fed. Reg. 4895 (Jan. 22, 2023); The White House, FACT SHEET: Biden-Harris Administration Highlights Commitment to Defending Reproductive Rights and Actions to Protect Access to Reproductive Health Care One Year After Overturning of Roe v. Wade (June 23, 2023), https://perma.cc/66WV-EVAM (collecting actions). The President's directive called on his administration to "consider[ ] updates to current guidance on obligations specific to emergency conditions and stabilizing care under" EMTALA. 87 Fed. Reg. at 42054.

Meanwhile, Congress has repeatedly entertained proposed legislation to authorize agencies to undertake pro-abortion initiatives. *E.g.*, Women's Health Protection Act of 2023, S. 701, 118th Cong. (2023); Women's Health Protection Act of 2023, H.R. 12, 118th Cong. (2023); Women's Health Protection Act of 2022, S. 4132, 117th Cong. (2022); Women's Health Protection Act of 2021, S. 1975, 117th Cong. (2021); Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. (2021); Let Doctors Provide Reproductive Health Care Act, S. 1297, 118th Cong. (2023); Let Doctors Provide Reproductive Health Care Act, H.R. 2907, 118th Cong. (2023); Right to Contraception Act, S. 1999, 118th Cong. (2023); Freedom to Travel for Health Care Act, S. 2053, 118th Cong. (2023); UPHOLD Privacy Act of 2023, S. 631, 118th Cong. (2023). It has declined every invitation.

President Biden did not wait for Congress to enact pro-abortion legislation. Instead, three days after issuing the executive order, the administration discovered a national abortion mandate in the silence of EMTALA, where it had evidently lain dormant for 36 years. HHS promptly issued novel "guidance" to "remind" hospitals receiving Medicare funds of a position it had never before taken: that EMTALA requires emergency room doctors to perform or complete abortions, including "incomplete" chemical-induced abortions, regardless of—or more likely, as a response to—state laws that would bar them. Centers for Medicare & Medicaid Services (CMS), *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (July 11, 2022). The memorandum's title tried to veil the titanic change, falsely labeling its novel directive as mere "reinforcement" of existing duties.

The memorandum insists that if "a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and … abortion is the stabilizing treatment necessary to resolve that condition, the physician *must* provide that treatment." *Id.* at 1. In nearly four decades since EMTALA was enacted, neither the statute nor previous federal guidance ever stated "obligations" requiring hospitals and physicians to provide any particular procedure, much less an abortion. The memorandum also purported to authorize private lawsuits, *id.* at 5, and insisted that "[a]ny state actions against a physician who provides an abortion in order to stabilize an emergency medical condition [as defined by that physician] in a pregnant individual presenting to the hospital would be preempted," *id.* at 5–6. And the administration threatened that if a hospital terminates its Medicare provider agreement to avoid this reinterpretation of EMTALA, CMS may penalize the hospital. *Id.* at 4.

PROCEEDINGS BELOW

Within weeks, the United States sued Idaho, seeking to enjoin the Defense of Life Act as preempted by EMTALA. *United States* v. *State of Idaho*, No. 1:22-cv-00329-BLW, J.A.1–23. The Idaho legislature moved to intervene and was given leave to file briefs and present oral argument on a limited basis, though the court later denied its request to intervene.[1]

[1] The decision was based on the court's factual determination that the Idaho legislature's interests were adequately represented by the State. Though the State has taken no position on intervention, the State and the legislature have both defended Idaho law and vigorously opposed the preemption theory.

The administration's claims were novel in procedure as well as substance. It was not doctors or patients who brought claims against hospitals accepting Medicare funds. Rather, the federal government sued the State, seeking a declaratory judgment and injunction under the Supremacy Clause.

The district court granted a preliminary injunction. J.A.620–56. It held that the Defense of Life Act was preempted by EMTALA for abortions necessary to avoid "(i) placing the health of a pregnant patient in serious jeopardy; (ii) a serious impairment to bodily functions of the pregnant patient; or (iii) a serious dysfunction of any bodily organ or part of the pregnant patient." J.A.656 (quotation marks omitted).

The State and the legislature moved for reconsideration. While those motions were pending, the Idaho Supreme Court issued its authoritative interpretation of the Defense of Life Act. *Planned Parenthood Great Nw.*, 522 P.3d at 1202–03. Thereafter, the legislature amended the Act with the changes noted above, including converting the affirmative defense that an abortion was necessary to protect the life of the mother to a statutory exception. Idaho Code § 18-622(2)(a)(i). The district court denied reconsideration. J.A.660–71.

The State and the legislature appealed, a stay of the injunction pending appeal was filed, and a unanimous Ninth Circuit panel granted a stay in a published order, concluding that "EMTALA does not preempt" Idaho's Defense of Life Act. J.A.695. It held there was no conflict between EMTALA and the Act, and the Act poses no obstacle to EMTALA's purpose. J.A.696–04.

The panel determined that conflict preemption did not exist. EMTALA "does not set standards of care or specifically mandate that certain procedures, such as abortion, be offered." J.A.696–97. And Congress did not intend EMTALA to supersede "the historic police powers of the States," including the right to prohibit abortion. J.A.698.

The panel also held that there was no obstacle preemption between the Act and EMTALA. Congress did not enact EMTALA "to create a national standard of care for hospitals," but "to respond to the specific problem of hospital emergency rooms refusing to treat patients who were uninsured or who could otherwise not pay for treatment." J.A.703 (cleaned up). Because of this, the Act's "limitations on abortion services do not pose an obstacle to EMTALA's purpose because they do not interfere with the provision of emergency medical services to indigent patients." J.A.704.

The panel further concluded that the remaining stay factors were met. The State would be irreparably harmed absent a stay because its democratically enacted law was enjoined. J.A.704–06. The balance of equities also favored a stay because "the federal government has no discernable interest in regulating the internal medical affairs of the State, and the public interest is best served by preserving the force and effect of a duly enacted Idaho law during the pendency of this appeal." J.A.707.

Within days, the en banc Ninth Circuit vacated the panel's stay opinion and granted en banc review even before a merits decision had issued. J.A.709. The en banc court provided no explanation of its order and nowhere addressed the analysis in the panel's stay opinion. J.A.710–11.

The State moved for a stay of the district court's injunction pending appeal and asked this Court to treat the application as a petition for a writ of certiorari before judgment. On January 5, 2024, the Court granted the stay and the petition.

SUMMARY OF THE ARGUMENT

The United States cannot establish the requirements to obtain a preliminary injunction. For that extraordinary relief, the administration must show that (1) it "is likely to succeed on the merits," (2) it "is likely to suffer irreparable harm in the absence of preliminary relief," (3) "the balance of equities tips in [its] favor," and (4) "an injunction is in the public interest." *Winter* v. *Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The government has not made any of these showings.

On the merits, EMTALA prohibits patient dumping; it does not supersede state standards of care. EMTALA operates *within* the menu of lawful treatments in a particular state and available at a particular hospital, requiring hospitals to offer stabilizing care *from that menu*. It neither authorizes nor requires hospitals to violate state law.

That general proposition is especially true here, because EMTALA does not even mention "abortion." Instead, the statute covers both pregnant mother and "unborn child" alike, 42 U.S.C. 1395dd(e)(1)(A)(i), and its requirement that indigent and paying clients be treated equally includes delivery of an "unborn child," 42 U.S.C. 1395dd(e)(3)(A). A medical provider complies with EMTALA when it offers stabilizing treatment in accord with state law and the hospital's capabilities. 42 U.S.C. 1395dd(a). That is exactly

what the Fifth Circuit held in *Texas*, 89 F.4th at 541–45, and that is why there is also no conflict between Idaho's Defense of Life Act and EMTALA.

The balance of harm weighs decisively in Idaho's favor, too. A state suffers irreparable injury when enjoined from implementing its law. The whole point of *Dobbs* was to restore to the states their authority to regulate abortion. Yet the administration seeks to thwart Idaho's exercise of self-government on this important topic. Conversely, denying an injunction causes no irreparable harm to the administration. Its claimed EMTALA abortion mandate is imaginary. The Medicare Act generally—and EMTALA specifically—preserve the right of states to regulate the practice of medicine, including on the issue of abortion.

Nor does the public interest support the district court's injunction. Reversing that injunction poses no threat to pregnant women's healthcare in Idaho because "Idaho's law expressly contemplates necessary medical care for pregnant women in distress." J.A.707 (citing Idaho Code § 18-622(4)). In sum, the administration has no legitimate interest in compelling Idaho's compliance with a supposed federal mandate that is contrary to EMTALA's text.

ARGUMENT

I. Three threshold interpretive principles place a high burden on the United States to prove that its reading of EMTALA is correct.

A. Courts presume that Congress does not preempt state regulation of medicine.

This Court's preemption analysis starts "with the assumption that the historic police powers of the States [are] not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *Wyeth* v. *Levine*, 555 U.S. 555, 565 (2009). "That assumption applies with particular force when Congress has legislated in a field traditionally occupied by the States." *Altria Grp., Inc.* v. *Good*, 555 U.S. 70, 77 (2008). This presumption, based on the "historic presence of state law," is so strong it applies even when the federal government has also regulated in an area "for more than a century." *Wyeth*, 555 U.S. at 565 n.3. Thus, in applying that presumption to a federal statute "susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Altria*, 555 U.S. at 77 (quoting *Bates* v. *Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)).

These principles pose a substantial obstacle to the United States' novel preemption theory. There is no question of "the historic primacy of state regulation of matters of health and safety." *Medtronic*, 518 U.S. at 485. The regulation of medicine is "a field which the States have traditionally occupied," *Wyeth*, 555 U.S. at 565 & n.3, and states have a deep interest "in protecting the integrity and ethics of the medical profession," *Glucksberg*, 521 U.S. at 731.

In fact, it is out of respect for these state regulations that the Medicare Act specifically disclaims any federal interference in the states' "control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. 1395; see also 42 U.S.C. 1395dd(f) (limiting EMTALA's preemptive effect to situations where state law "*directly conflicts* with a requirement of this section" (emphasis added)).

B. Congress must speak unambiguously through Spending Clause legislation like EMTALA.

EMTALA is Spending Clause legislation, which "is much in the nature of a contract," and "thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst*, 451 U.S. at 17. Because "[t]here can … be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it," Congress must "speak with a clear voice" and impose conditions on spending legislation "unambiguously." *Id.* at 17–18.

EMTALA provides no "clear notice" that it mandates abortion, *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006), but rather the opposite: it directs covered hospitals to provide care for "the unborn child," 42 U.S.C. 1395dd(e)(1)(A)(i). That is why, throughout the nearly first four decades of EMTALA's enactment, no federal official or court construed it the way the administration now does.

Ultimately, covered hospitals could opt out of EMTALA by "not using federal funds and withdrawing from the federal program entirely." *Guardians*

Ass'n v. *Civ. Serv. Comm'n of N.Y.*, 463 U.S. 582, 596 (1983) (quotation omitted). While "the option of ceasing to act" is not sufficient to defeat a direct conflict between state and federal law for legislation enacted under Congress's other powers, see *Mut. Pharm. Co., Inc.* v. *Bartlett*, 570 U.S. 472, 488 (2013), it is sufficient under the Spending Clause, where legislation turns on the acceptance of the federal government's terms. That covered hospitals could take such an action again highlights that the federal government's remedy is to seek penalties against hospitals who accept federal funds but fail to comply with its requirements—not to sue Idaho to enforce requirements the State did not accept. 42 U.S.C. 1395dd(d)(1).

C. Congress speaks clearly when it addresses questions of major political significance.

The major-questions doctrine is based on "both separation of powers principles and a practical understanding of legislative intent." *West Virginia* v. *E.P.A.*, 597 U.S. 697, 723 (2022). It is rooted in the common-sense presumptions that "Congress intends to make major policy decisions itself," *ibid.* (citation omitted), that Congress does not "hide elephants in mouseholes," *Whitman* v. *Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001), and that Congress refrains from settling important political issues using "cryptic" language, *West Virginia*, 597 U.S. at 721.

The major-questions framework applies to this case. Enacting an emergency-room mandate that overrides state-law standards of care—whether those involve experimental medications, marijuana, or abortion—is a matter of undoubted "political significance." *West Virginia*, 597 U.S. at 721.

As for state abortion laws, even the administration concedes that "when Congress intends to create special rules governing abortion …, it does so explicitly." Appl.Opp.33–34 (citations omitted). The "lack of historical precedent" for invoking EMTALA to mandate abortions further confirms that the major-questions principles apply. *NFIB* v. *Dep't of Lab., Occupational Safety & Health Admin.*, 595 U.S. 109, 119–20 (2022) (per curiam).

The same is true of "the sheer scope" of the government's reading of EMTALA, *Ala. Ass'n of Realtors* v. *Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021) (per curiam). The administration's reimagining of the statute would override state law in emergency rooms *whenever* a doctor deems an unlawful treatment necessary for stabilizing care.

Under major-questions principles, the Court should meet with a considerable "measure of skepticism" the administration's claim that Congress mandated abortions without even mentioning that word in the statute. *Util. Air Regul. Grp.* v. *E.P.A.*, 573 U.S. 302, 324 (2014). For the United States to make its case, it must point to "clear congressional authorization." *West Virginia*, 597 U.S. at 723. A "plausible" or "colorable textual basis" will not suffice. *Id.* at 722–23.

Here, the administration's reading of EMTALA is not even plausible, as explained below. It is inconceivable that Congress overrode all state medical regulations—including state-by-state abortion regulations—through a federal anti-dumping statute that protects indigent people in emergency rooms without ever mentioning the word "abortion."

II. EMTALA does not require emergency rooms to become abortion enclaves in violation of state law.

A "direct conflict[ ]," 42 U.S.C. 1395dd(f), between EMTALA and state law could occur in only two instances. First, if compliance with both EMTALA and a state law is "impossible." *Crosby* v. *Nat'l Foreign Trade Council*, 530 U.S. 363, 372–73 (2000) (citing *Fla. Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132, 142–43 (1963)). And second, if a state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *English* v. *Gen. Elec. Co.*, 496 U.S. 72, 79 (1990) (citation omitted). But see *Wyeth*, 555 U.S. at 594 (Thomas, J., concurring) ("This Court's entire body of 'purposes and objectives' pre-emption jurisprudence is inherently flawed."). Neither type of conflict exists here, so the district court's injunction must be vacated and its decision reversed.

A. It is not impossible to comply with EMTALA and Idaho's Defense of Life Act.

EMTALA creates no impossibility conflict with Idaho law. Indeed, the two do not conflict at all.

The administration says EMTALA requires hospital emergency department doctors to perform abortions *whenever* those doctors subjectively believe an abortion is "stabilizing care." But EMTALA only requires hospitals to offer treatments that are "available." In Idaho, the abortions for which the administration vies are not "available" to any patient. EMTALA does not require hospital emergency rooms to become abortion enclaves in violation of state law. *Texas*, 89 F.4th at 545 (EMTALA does not "mandate[] physicians to provide abortions when that is the necessary stabilizing treatment for an emergency medical condition.").

1. EMTALA imposes no federal standard of care, much less a standard that conflicts with Idaho law.

The Defense of Life Act generally prohibits abortion in Idaho except in cases of rape or incest or if a doctor believes—"in his good faith medical judgment and based on the facts known to [him] at the time"—that it is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a). Removing the remains of a dead, unborn child or removing an ectopic or molar pregnancy is not an "abortion." Idaho Code § 18-604(1). EMTALA does not mandate abortions in cases where the Defense of Life Act prohibits them.

Congress recognized that the Medicare Act—which includes EMTALA—"shall [not] be construed" to interfere with "the practice of medicine or the manner in which medical services are provided." 42 U.S.C. 1395. Regulating the practice of medicine is one of "the historic police powers of the States" that federal law is presumed not to displace. *Medtronic*,

518 U.S. at 485. This statutory provision "underscores the 'congressional policy against the involvement of federal personnel in medical treatment decisions.'" *Texas*, 89 F.4th at 542 (quoting *United States* v. *Univ. Hosp., State Univ. of N.Y. at Stony Brook*, 729 F.2d 144, 160 (2d Cir. 1984)). That is why Congress prohibited the government from "direct[ing] or prohibit[ing] any [particular] kind of treatment or diagnosis" in administering Medicare. *Goodman* v. *Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989) (per curiam). So EMTALA cannot be construed to demand specific procedures. Like the rest of the Medicare Act, it leaves state standards of care intact.

EMTALA's statutory text confirms this. It begins by requiring hospitals to screen patients who come to the emergency department "to determine whether … an emergency medical condition … exists." 42 U.S.C. 1395dd(a). If such a condition exists, hospitals must provide, "within the staff and facilities *available at the hospital*, for such further medical examination and such treatment as may be required to stabilize the medical condition, or … for transfer of the individual to another medical facility." 42 U.S.C. 1395dd(b)(1) (emphasis added). This directive necessarily precludes treatments that state law prohibits because such treatments are not "available at the hospital." 42 U.S.C. 1395dd(b)(1).

Nothing in EMTALA indicates Congress intended it to supersede a state's limitations on what treatments are generally "available" to any patient. For example, if a person presents with a condition that could result in "serious impairment to bodily functions" unless she gets immediate treatment, 42 U.S.C. 1395dd(e)(1)(A)(ii), and the attending physician believes that condition could be stabilized with

an experimental medication that state law forbids, EMTALA would not authorize or require that the medication be prescribed anyway. The physician's judgment does not override contrary state regulations and make that medication "available" at the hospital. And if no other treatments are available to stabilize the patient—an unlikely event given the capacious meaning of "stabilizing treatment" that encompasses many treatment options—the hospital complies with EMTALA by providing a transfer. EMTALA's demands are focused on ensuring that every patient—whether insured, paying out of pocket, or having no money or coverage at all—is treated the same within the bounds of the hospital's capabilities and state law.

That is why every circuit to have addressed the question has uniformly held that EMTALA does not create a national standard of care. *E.g.*, *Gatewood* v. *Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (EMTALA does not duplicate standards of care but instead creates a cause of action "for what amounts to failure to treat"); *Correa* v. *Hosp. San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) ("EMTALA does not create a cause of action for medical malpractice"; it prohibits "disparate" treatment); *Hardy* v. *N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789, 792–93 (2d Cir. 1999) (EMTALA is not intended "to provide a federal remedy for misdiagnosis or medical negligence" but to impose a legal duty "to provide emergency care to all") (citations omitted); *Torretti* v. *Main Line Hosps., Inc.*, 580 F.3d 168, 173–74 (3d Cir. 2009) (EMTALA "does not create liability for malpractice based upon breach of national or community standard of care"; "the statute was aimed at disparate patient treatment") (citation omitted); *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142–43

(4th Cir. 1996) (EMTALA "does not provide a cause of action for routine charges of misdiagnosis or malpractice," only for "what amounts to failure to treat") (citations omitted); *Cleland* v. *Bronson Health Care Grp., Inc.*, 917 F.2d 266, 268, 272 (6th Cir. 1990) (EMTALA's terms "preclude[ ] resort to a malpractice or other objective standard of care"; hospital need merely "act[ ] in the same manner as it would have for the usual paying patient"); *Nartey* v. *Franciscan Health Hosp.*, 2 F.4th 1020, 1025 (7th Cir. 2021) (per curiam) ("We therefore join the chorus of circuits that have concluded the EMTALA cannot be used to challenge the quality of medical care") (collecting cases); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136–38 (8th Cir. 1996) (en banc) ("every court that has considered EMTALA has disclaimed any notion that it creates a general federal cause of action for medical malpractice in emergency rooms"; plaintiffs are entitled "to be treated as other similarly situated patients are treated, within the hospital's capabilities") (citations omitted); *Urban By & Through Urban* v. *King*, 43 F.3d 523, 525 (10th Cir. 1994) (EMTALA "is neither a malpractice nor a negligence statute"); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 & n.2 (11th Cir. 1994) (EMTALA creates no negligence or malpractice claims; indigent patients need merely be treated the same as other patients).

And it is also why the Fifth Circuit rejected the administration's position in this very context: "EMTALA does not impose a national standard of care." *Texas*, 89 F.4th at 543. The United States cannot escape the consequences of this point—just as a patient who wanted, but was denied, an abortion cannot wield EMTALA to force an emergency room to perform one, neither can the federal government.

The administration has insisted that courts "have long recognized that abortion care is among the treatments required as stabilizing treatment under EMTALA." Appl.Opp.29. But none of the four pre-*Dobbs* district court decisions on which the administration has relied actually says that—much less strikes down any state law on that basis.

California v. *United States* upheld a federal conscience law allowing doctors to *refrain* from performing abortions, despite the argument that EMTALA required them. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008). *Morin* v. *Eastern Maine Medical Center* concerned not an abortion but whether to deliver an unborn child that was already dead. 780 F. Supp. 2d 84, 86 (D. Me. 2010). *Ritten* v. *Lapeer Regional Medical Center* involved a factual dispute about whether a patient "was truly in labor" and required premature delivery. 611 F. Supp. 2d 696, 715 (E.D. Mich. 2009). And *New York* v. *U.S. Department of Health & Human Services* was not an EMTALA case at all but a ruling against the Trump administration's regulation enforcing federal conscience laws, a regulation the current administration rescinded after *Dobbs*. 414 F. Supp. 3d 475, 537–39 (S.D.N.Y. 2019), *appeal withdrawn by* No. 19-4254, 2022 WL 17974424 (2d Cir. Dec. 8, 2022).

To transform EMTALA into a state-law wrecking ball would require repealing the Medicare Act's savings clause, rewriting 42 U.S.C. 1395dd(b)(1)(A) to require "treatment as may be required to stabilize [an emergency] medical condition [*regardless of whether such treatment is authorized under state law*]," and removing states as the principal regulators of the practice of medicine. Unsurprisingly, the administra-

tion has cited no authority for this extraordinary reading, which is contrary to "the language and design of the statute as a whole." *K Mart Corp.* v. *Cartier, Inc.*, 486 U.S. 281, 291 (1988).

EMTALA's focused mandate merely ensures that indigent patients are not denied treatments that are authorized under state law for paying patients. *Texas*, 89 F.4th at 542 (EMTALA judges a hospital's action "by whether it was performed equitably in comparison to other patients with similar symptoms") (quoting *Marshall*, 134 F.3d at 322). In other words, EMTALA takes state standards of care—and hospitals' capabilities—as it finds them.

The Ninth Circuit's pre-*Dobbs* decision in *Baker* v. *Adventist Health, Inc.* is illustrative. 260 F.3d 987 (9th Cir. 2001). There, the plaintiff argued that EMTALA required a 40-bed rural hospital to offer psychiatric treatment. *Id.* at 991. The hospital operated an emergency room but did not offer psychiatric treatment and had no psychiatrists or any other mental health professionals on staff. *Ibid.* The court held that forcing a hospital to provide treatment beyond its capability was "not a tenable position under the statute." *Id.* at 993.

Just as EMTALA does not require emergency rooms to provide psychiatric services that are not available on site, it does not require emergency rooms to provide treatments that are unavailable because state law forbids them. If emergency rooms need not hire psychiatrists, they certainly do not have to employ abortion providers.

EMTALA does not override other state laws, either. Though physicians are regulated by state medical-practice standards, the administration's view

would allow doctors' professional judgment to supersede those standards in the emergency room, making doctors a law unto themselves. See J.A.698 (noting that "a medical professional may believe an organ transplant is necessary to stabilize a patient's emergency medical condition, but EMTALA would not then preempt a state's requirements governing organ transplants"). If physician judgment becomes the trump card, emergency-room doctors could administer an experimental drug that is neither FDA-approved nor covered by Medicare. Cf. *Abigail All. for Better Access to Development Drugs* v. *von Eschenbach*, 495 F.3d 696 (D.C. Cir. 2007). Despite contrary state law, they could also treat emergency mental-health conditions with marijuana or euthanasia medications, and could treat children with electroconvulsive therapy or psychosurgery, including lobotomies. *E.g.*, Idaho Code § 37-2705(d)(28) (THC schedule I controlled substance); *id.* § 39-4514; (prohibition on euthanasia); *id.* § 16-2423(3) (prohibition on pediatric psychosurgery and electroconvulsive treatment).

Perhaps most troubling, the United States' novel theory would open the same "mental health" loophole for abortion as *Roe*. It would authorize emergency-room doctors to perform abortions whenever they say those abortions are necessary to avoid "serious jeopardy" to the mother's mental health. 42 U.S.C. 1395dd(e)(1)(A)(i). That would turn emergency rooms into federal abortion enclaves governed not by state law but by subjective physician judgment. The administration's conception of preemption results in wide latitude to perform abortions for the alleged purpose of treating mental health—no matter how broadly that concept might stretch.

Beyond failing to establish that EMTALA's text preempts Idaho law, the administration has also been unable to show any practical conflict between EMTALA and the Defense of Life Act. It proffered declarations from physicians who described various emergency-room situations where, in their medical judgment, abortion was appropriate. J.A. 24–44, 354–76, 596–619. But none of those situations pose a conflict with Idaho law. For instance, several declarations address ectopic pregnancies. J.A. 30–32, 606–09, 618. Yet treating an ectopic pregnancy is consistent with the Defense of Life Act. See Idaho Code § 18-604(1)(c); *United States* v. *Idaho*, 83 F.4th 1130, 1137 (9th Cir. 2023).

As the Ninth Circuit stay panel noted, every other circumstance those declarations describe involved life-threatening circumstances, such that Idaho law would allow an abortion because the physician determined "in his good faith medical judgment" that it was necessary to "prevent the death" of the mother. Idaho Code § 18-622(2)(a)(i); J.A.667 (citing *Planned Parenthood Great Nw.*, 522 P.3d at 1203). The administration offered no evidence of a situation where abortion is the *only* possible stabilizing treatment for a mother facing a non-life-threatening medical condition.

Of course, because the question presented focuses on preemption, the Court need only decide whether EMTALA requires abortions that Idaho law forbids. Neither EMTALA's text nor its purpose requires those abortions. It is enough for the Court to hold that. EMTALA gives patients the right "to be treated as other similarly situated patients are treated, within the hospital's capabilities." *Summers*, 91 F.3d at 1138. The statute does not give patients a federal

right to receive in the emergency room what state law prohibits providing to anyone.

2. EMTALA requires hospitals to care for an unborn child.

EMTALA cannot be read to require abortions for a second reason: its text demands equal treatment for "the unborn child." 42 U.S.C. 1395dd(e)(1)(A)(i). In 1989, Congress added the phrase "unborn child" to EMTALA, defining "emergency medical condition" to include a condition that jeopardizes the health of either "the woman or her unborn child." *Ibid.*; see Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h), 103 Stat. 2106, 2248 (Dec. 19, 1989). On top of requiring care to stabilize an unborn child who presents with an emergency medical condition, 42 U.S.C. 1395dd(e)(3)(A), EMTALA also requires that patient transfers (1) minimize risks to the unborn child, 42 U.S.C. 1395dd(c)(2)(A); (2) do not threaten the health or safety of the unborn child, 42 U.S.C. 1395dd(e)(1)(B)(ii); and (3) assess the medical benefits to the unborn child, 42 U.S.C. 1395dd(c)(1)(A)(ii). So "EMTALA imposes obligations on physicians with respect to both the pregnant woman and her unborn child." *Texas*, 89 F.4th at 544 (citation omitted).

Again, EMTALA does not mandate any specific services or standard of care, merely equal treatment. So when a woman is in active labor, EMTALA requires the hospital to deliver the unborn child and placenta, even if the mother is unable to pay. 42 U.S.C. 1395dd(e)(3)(A); see also U.S. Br. at 39, *Texas* v. *Becerra*, No. 23-10246 (5th Cir. May 1, 2023) (citing 42 U.S.C. 1395dd(e)(3)(A) and acknowledging that EMTALA requires a hospital to deliver an unborn

child of a woman in active labor). "The inclusion of [this] one stabilizing treatment indicates the others are not mandated." *Texas*, 89 F.4th at 542 (citation omitted); cf. *Bittner* v. *United States*, 598 U.S. 85, 94 (2023) (applying the *expressio unius est exclusio alterius* canon). It is particularly unlikely that EMTALA overrides state law in the context of abortion given its solicitude for the child.

The administration's primary case in opposition to the stay application, *In re Baby "K" (Three Cases)*, 16 F.3d 590 (4th Cir. 1994), is a perfect illustration of EMTALA's care for all human life—and its narrow preemptive sweep. There, the Fourth Circuit held that a physician's EMTALA duty to stabilize an already-born baby preempted a hospital's claim that it could withhold stabilizing care that it deemed "medically or ethically inappropriate." *Id.* at 597 (quoting Va. Code Ann. § 54.1-2990 (1993)).

The child had anencephaly—"a congenital malformation in which a major portion of the brain, skull, and scalp are missing"—rendering her "permanently unconscious." *Id.* at 592. So only the baby, not the mother, had an emergency medical condition. *Ibid.*

There was no question that Virginia state law allowed the stabilizing care requested—placing the child on a ventilator—because the hospital had previously provided that care to Baby K. *Id.* at 592–93. That was why the Fourth Circuit rejected the hospital's attempt to invoke Virginia law to allow a physician to let the child die, holding that approach preempted by EMTALA's "stabilizing treatment" requirement. *Id.* at 597.

In other words, the administration relies on a case that required hospitals to *preserve* a child's life as grounds to require them to take it. In so doing, the administration says that because EMTALA references "the woman *or* her unborn child," 42 U.S.C. 1395dd(e)(1)(A)(i) (emphasis added), then if it comes down to a choice of the child's life or the mother's fertility, for example, the mother's non-life-threatening interest always prevails. Appl.Opp.32–33. That is not a faithful reading of the word "or" in the statutory text. "If you are offered coffee or tea, you may pick either … or you may for whatever reason order both. This is the ordinary sense of the word, understood by everyone." Bryan A. Garner, *Garner's American Modern Usage* 45 (2d ed. 2003). See generally *Union Ins. Co.* v. *United States*, 73 U.S. (6 Wall.) 759, 764 (1867) (when "the obvious intent" is "that the word 'or' must be taken conjunctively," then that is how the word should be interpreted).

To put it another way, EMTALA does *not* force a choice between mother and child. As a result, there can be no impossibility conflict with an Idaho statute that requires saving the child's life in such circumstances.

Tellingly, the administration's position also conflicts with the Hyde Amendment, which prohibits federal funds from being "used to pay for abortions except in cases of danger to the life of the mother, rape, or incest," *Planned Parenthood Ariz. Inc.* v. *Betlach*, 727 F.3d 960, 964 (9th Cir. 2013). And its position further conflicts with several abortion-specific laws that prevent agencies from requiring healthcare providers to perform abortions. *E.g.*, Consol. Appropriations Act of 2023, Pub. L. No. 117-328, Div. B., Tit. II, § 203, 136 Stat. 4459, 4541 (Dec.

29, 2022) (restricting DOJ from using any funds to "require any person to perform, or facilitate in any way the performance of, any abortion."); *id.* at Div. H., Tit. V, § 507(d)(1) (restricting HHS from requiring healthcare entities to facilitate abortions). So if the administration is right—that EMTALA requires abortions to stabilize emergency medical conditions that fall short of threatening the life of the pregnant woman—then federal law would simultaneously override state law to *mandate* the performance of certain abortions while *prohibiting* the use of federal funds to pay for them. EMTALA's text in no way supports attributing to Congress such incoherence.

The administration's opportunistic attempt to assert powers that it "never previously claimed" is troubling indeed. *Biden* v. *Nebraska*, 143 S. Ct. 2355, 2372 (2023). And it has consequences not just for Idaho's sovereignty and its citizens but for others beyond this case. For example, the federal government's revisionist interpretation of EMTALA seeks to immunize doctors who provide abortions from complying with state law. But its new statutory reading also coerces emergency-room doctors to perform or complete abortions, including "incomplete medical abortion[s]," contrary to their deeply held beliefs. CMS, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (July 11, 2022); see also *Texas* v. *Becerra*, 623 F. Supp. 3d 696, 716, 728 (N.D. Tex. 2022). HHS is already threatening hospitals and physicians with six-figure fines for failing to comply with a non-existent abortion mandate. U.S. Dep't of Health & Hum. Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023). The Court should reject this mangling of EMTALA.

B. Idaho law is no obstacle to EMTALA's purpose.

EMTALA's call for stabilizing care to prevent patient dumping does not mandate abortion or any other procedure. Accordingly, a state law defining when abortion may be performed—in line with the historic police powers of states as reaffirmed in *Dobbs*—is no obstacle to a statute seeking to prevent patient dumping.

Assuming there is a place for so-called obstacle preemption, cf. *Wyeth*, 555 U.S. at 594 (Thomas, J., concurring), the starting place is to establish, based on text and structure, Congress's purpose and objective in enacting EMTALA. On that subject, the circuits have spoken with one voice until now: to prevent patient dumping or otherwise refusing to treat indigent patients who present to emergency rooms. *E.g.*, *Texas*, 89 F.4th at 542 ("the purpose of EMTALA is to provide emergency care to the uninsured") (citation omitted). Accord, *e.g., Brooker* v. *Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991) (citing H.R. Rep. No. 241, 99th Cong., 2d Sess. 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605, and Note, *Preventing Patient Dumping*, 61 N.Y.U. L. Rev. 1186, 1187–88 (1986)); *Hardy*, 164 F.3d at 792; *Bryan* v. *Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996); *Marshall*, 134 F.3d at 322; *Cherukuri* v. *Shalala*, 175 F.3d 446, 450 (6th Cir. 1999); *Martindale* v. *Ind. Univ. Health Bloomington, Inc.*, 39 F.4th 416, 419, 423 (7th Cir. 2022); *Harry* v. *Marchant*, 291 F.3d 767, 772–73 (11th Cir. 2002).

The Defense of Life Act poses no obstacle to the goal of prohibiting patient dumping. The Act does not direct that uninsured patients presenting to an

emergency department be sent away without medical treatment while comparable patients with money or insurance are treated. Instead, the Act addresses a topic that EMTALA does not—abortion—and it affirms that unborn life is generally protected in Idaho.

If anything, the Defense of Life Act and EMTALA share a common purpose: to protect unborn life. Indeed, both statutes have specific, detailed language manifesting that purpose. Far from being at cross-purposes, then, Idaho's law and EMTALA run along the same track. Accordingly, Idaho's protection for the unborn is no obstacle to EMTALA's anti-patient dumping purpose, and the Court should invalidate the district court's contrary holding.

* * *

EMTALA is a basic law with a clear purpose: to stop hospitals from dumping indigent patients. There is zero evidence Congress enacted EMTALA to mandate abortions, much less to run roughshod over state judgments on appropriate medical treatments. Quite the opposite, Congress amended the statute in four places to require hospitals to protect the "unborn child." Pub. L. No. 101-239, § 6211(c), (h), 103 Stat. 2106, 2248 (1989); see also *Texas*, 89 F.4th at 545 ("EMTALA does not provide an unqualified right for the pregnant mother to abort her child especially when EMTALA imposes equal stabilization obligations."). Because "[t]he purpose of Congress is the ultimate touchstone in every pre-emption case," *Medtronic*, 518 U.S. at 485 (cleaned up), the United States is unlikely to prevail on the merits of its pre-emption claim.

III. The equities favor Idaho.

The administration cannot show a likelihood of success on its preemption claim—not even a serious question going to the merits. Accordingly, there is no need to consider the other *Winter* factors. *Whole Woman's Health* v. *Jackson*, 141 S. Ct. 2494, 2495 (2021); *Trump* v. *Hawaii*, 585 U.S. 667, 710–11 (2018). But those factors, too, weigh in Idaho's favor.

A. The administration is experiencing no harm, let alone irreparable harm.

The United States is suffering no harm. It has no legitimate interest in applying EMTALA to override the Defense of Life Act because EMTALA does not preempt the Act. Given that the government has no interest in enforcing federal law in illegal ways, it cannot establish irreparable harm. See *Ala. Ass'n of Realtors.*, 141 S. Ct. at 2490 ("our system does not permit agencies to act unlawfully").

The administration's lack of harm is exposed—and its unreasonable statutory interpretation highlighted—by the fact that it did not raise its novel preemption theory until more than three decades after EMTALA was enacted and the alleged conflict between EMTALA and Idaho law first arose. Idaho has long prohibited abortions that the administration says EMTALA requires. Before *Dobbs* and the Defense of Life Act, Idaho was one of 17 states that prohibited abortions after viability; six more states prohibited abortion after 24 weeks, and another state after 25 weeks. Idaho Code, § 18-608 (enacted in 1973); Godlasky, Ellis, & Sergent, *Where is abortion legal? Everywhere. But* . . ., USA Today (Apr. 23, 2020), https://perma.cc/Q8JW-PPTN. Yet the federal

government never claimed that any of these laws conflicted with and were therefore preempted by EMTALA. This over-three-decade delay confirms the lack of irreparable injury and an opportunistic (and baseless) interpretation of a plain statute.

B. The balance of equities and public interest favor Idaho.

The balancing of the equities and the public interest merge when the United States is a party. *Nken* v. *Holder*, 556 U.S. 418, 435 (2009). Those factors weigh decisively against the district court's injunction.

Notably, the Court need not balance the equities or the public interest by "weigh[ing] … tradeoffs" in a case like this, where the government has acted unlawfully. *NFIB*, 595 U.S. at 120. In those situations, the Court recognizes that balancing any competing interests "is the responsibility of those chosen by the people through democratic processes." *Ibid.* Here, Congress has done that by crafting EMTALA so that it does not preempt state laws like Idaho's. That decision should be respected.

Regardless, the balance of competing interests tips sharply toward Idaho. The harm to the State is substantial. A State's "inability to enforce its duly enacted plans clearly inflicts irreparable harm on the State." *Abbott* v. *Perez*, 585 U.S. 579, 602 n.17 (2018) (citing *Maryland* v. *King*, 567 U.S. 1301 (2012) (Roberts, C.J., in chambers); accord *New Motor Vehicle Bd.* v. *Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977) (Rehnquist, J., in chambers). That principle applies with full force here.

Idaho enacted the Defense of Life Act anticipating that this Court would restore to the states their authority to regulate abortion. *Dobbs* did precisely that, returning "to the people and their elected representatives" the power to "regulat[e] or prohibit[ ] abortion." 597 U.S. at 302. A court order blocking that return of sovereign authority would thwart Idaho's exercise of self-government on a matter of critical social and political significance. This causes irreparable harm to Idaho, its republican institutions, and its people.

The district court's injunction impairs not only Idaho's sovereignty but also its interest in preserving "prenatal life at all stages of development" and its interest in protecting "the integrity of the medical profession." *Dobbs*, 597 U.S. at 301. That injunction empowers emergency-room physicians who want to perform abortions to do so in violation of state law, and it compels doctors who object to abortion to participate in it. That risks the loss of unborn life and harm to the medical profession.

On the flip side, as the stay panel recognized, "Idaho's law expressly contemplates necessary medical care for pregnant women in distress." J.A.707 (citing Idaho Code § 18-622(4)). There is no reasonable prospect, for example, that a woman experiencing an ectopic pregnancy will be denied life-saving medical care. Idaho Code § 18-622(2).

In short, the equitable balance and public interest favor Idaho. The irreparable harm to Idaho's sovereignty and the pro-life interests of its people vastly outweigh any purported injuries that the United States asserts from its inability to rewrite EMTALA.

IV. The district court's injunction is overbroad.

The district court separately erred by entering an overbroad injunction.

Injunctive relief must be narrowly tailored to remedy the specific harm alleged. See *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979) ("injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs"). The district court says it enjoined Idaho from enforcing Idaho Code § 18-622(2)–(3) "as applied to medical care" required by EMTALA. J.A.656. Yet the very next sentence prohibits Idaho from taking certain actions against medical providers or hospitals based on their performance of conduct "that is necessary to avoid" an emergency medical condition. J.A.656.

This "necessary to avoid an emergency medical condition" standard does not align with EMTALA's definition of stabilizing treatment. Rather, it greatly expands the statute's scope. Under EMTALA, "to stabilize" means to provide "such medical treatment of the condition *as may be necessary to assure*, within reasonable medical probability, *that no material deterioration of the condition is likely* to result from or occur during the transfer of the individual from a facility." 42 U.S.C. 1395dd(e)(3)(A) (emphasis added). EMTALA uses a "necessary to assure no material deterioration" standard and applies that standard to patients that present with an existing emergency condition. This is obviously different, and much narrower, than the district court's "necessary to avoid an emergency medical condition" standard.

CONCLUSION

The district court's judgment should be reversed.

Respectfully submitted,

JOHN J. BURSCH
ERIN M. HAWLEY
MATTHEW S. BOWMAN
LINCOLN DAVIS WILSON
JACOB P. WARNER
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001

JAMES A. CAMPBELL
JULIE MARIE BLAKE
RORY GRAY
ALLIANCE DEFENDING FREEDOM
44180 Riverside Pkwy
Lansdowne, VA 20176

RAÚL R. LABRADOR
ATTORNEY GENERAL
ALAN M. HURST
SOLICITOR GENERAL
JOSHUA N. TURNER
Counsel of Record
JAMES E.M. CRAIG
700 W Jefferson St #210
Boise, ID 83720
josh.turner@ag.idaho.gov
(208) 332-3548

CHARLES J. COOPER
DAVID H. THOMPSON
PETER A. PATTERSON
MEGAN M. WOLD
COOPER & KIRK PLLC
1523 New Hampshire NW
Washington, DC 20036

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