Nos. 23A469 and 23A470

IN THE SUPREME COURT OF THE UNITED STATES

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL. (No. 23A469); STATE OF IDAHO (No. 23A470), APPLICANTS

v.

UNITED STATES OF AMERICA

RESPONSE IN OPPOSITION TO THE APPLICATIONS FOR A STAY

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The Solicitor General, on behalf of the United States, respectfully submits this response in opposition to the applications for a stay of the preliminary injunction entered by the United States District Court for the District of Idaho.

Pregnant women can experience emergency medical conditions that threaten their lives or risk severe and lasting harms, including sepsis, uncontrollable bleeding, kidney failure, and loss of fertility. When a woman experiencing such an emergency condition presents in a Medicare-funded hospital, the Emergency Medical Treatment and Labor Act (EMTALA) requires the hospital to offer "necessary stabilizing treatment." 42 U.S.C. 1395dd(b)(1). In some cases, the medically necessary care is termination of the pregnancy. And in those limited but critically important

circumstances, EMTALA requires the hospital to offer that care. As providers, courts, and Congress have long recognized, the Act's plain text mandates that result.

This case concerns the interaction between EMTALA and Idaho Code § 18-622, which took effect in August 2022. Section 18-622 makes it a felony for a doctor to terminate a pregnancy unless doing so is "necessary" to prevent the patient's "death." That exception is narrower than EMTALA, which by its terms protects patients not only from imminent death but also from emergencies that seriously threaten their health. Idaho law thus criminalizes care required by federal law: Under Section 18-622, an emergency-room physician who concludes that a pregnant woman needs an abortion to stabilize a condition that would otherwise threaten serious and irreversible harm may not provide the necessary care unless and until the patient's condition deteriorates to the point where an abortion is needed to save her life.

The United States sued Idaho, seeking a preliminary injunction against enforcement of Section 18-622 in circumstances where it prohibits care required by EMTALA. The district court agreed that EMTALA preempts Section 18-622 to the extent of that conflict and granted a narrow injunction tailored to the emergency situations covered by EMTALA. That injunction was entered before Section 18-622 took effect and has been in place almost continuously for more than 15 months.

This Court should deny applicants' belated requests to stay that injunction. As the district court recognized, when state law criminalizes essential care required by federal law, ordinary principles of preemption require state law to give way. Applicants' various attempts to justify a departure from the natural reading of EMTALA's text are unpersuasive, and many of their arguments are forfeited as well.

Applicants also fail to establish that the equities warrant a stay. Applicants' striking and unexplained delay in seeking relief -- and the State's failure to seek a stay in the lower courts at all -- belie their assertions of irreparable harm. And on the other side of the ledger, the narrow preliminary injunction is preserving the status quo and protecting women and doctors in Idaho from the devastating harms that would result if doctors could be subjected to criminal prosecution for providing essential emergency care.

STATEMENT

A. Background

1. Medicare is a federally subsidized health insurance program for the elderly and certain individuals with disabilities. Participation is voluntary, but if a hospital chooses to participate and becomes eligible for payments for providing care to Medicare patients, it must comply with certain conditions. See, e.g., 42 U.S.C. 1395cc. Among other things, every hospital that elects

to participate in Medicare and has an emergency department must abide by EMTALA. See 42 U.S.C. 1395cc(a)(1)(I)(i).

EMTALA requires covered hospitals to provide "[n]ecessary stabilizing treatment" to "any individual" who "comes to [the] hospital" with an "emergency medical condition." 42 U.S.C. 1395dd(b)(1) (emphasis omitted). An individual has an "emergency medical condition" when "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). "[T]o 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). A "transfer" includes a discharge from the hospital. 42 U.S.C. 1395dd(e)(4).[1]

Hospitals that fail to comply with EMTALA may be subject to civil penalties of more than $100,000 per violation, 42 U.S.C.

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[1] EMTALA authorizes transfer to another medical facility in appropriate cases. 42 U.S.C. 1395dd(b)(1)(B). That provision -- which authorizes transfer if, among other things, the hospital has "provide[d] the medical treatment within its capacity which minimizes the risks to the individual's health," 42 U.S.C. 1395dd(c)(2)(A) -- is not at issue here.

1395dd(d)(1) and (2); 42 C.F.R. 1003.510, and can lose their Medicare funding, 42 U.S.C. 1395cc(b). Likewise, treating physicians who violate EMTALA face civil penalties and exclusion from Medicare and state healthcare programs. 42 U.S.C. 1395dd(d)(1).

EMTALA also includes an express preemption provision, which specifies that "[t]he provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. 1395dd(f).

2. This case concerns Idaho Code § 18-622, which criminalizes most abortions in the State. In its current form, Section 18-622 allows only those abortions "necessary to prevent the death of the pregnant woman," id. § 18-622(2)(a)(i); to terminate "an ectopic or molar pregnancy," id. § 18-604(1)(c); or to terminate certain pregnancies resulting from rape or incest, id. § 18-622(2)(b).[2] Otherwise, the statute makes it a felony punishable by two to five years' imprisonment -- and by suspension or revocation of the healthcare professional's license -- to "perform[]," "attempt[] to perform," or "assist[] in performing or attempting

[2] Before amendments post-dating the entry of the preliminary injunction, the provision permitting abortions necessary to prevent the pregnant woman's death functioned only as an affirmative defense, Idaho Code Ann. § 18-622(3)(a)(ii) (2022), and the law did not exclude "removal of an ectopic or molar pregnancy" from its definition of abortion, see H.B. 374, § 1, 67th Leg., 1st Reg. Sess. (Idaho 2023), https://perma.cc/ZTZ7-HHWK (amending Idaho Code § 18-604(1)).

to perform" treatment that involves pregnancy termination. Id. § 18-622(1).

Section 18-622 was originally enacted in 2020, but the Legislature included a provision specifying that it would not take effect until 30 days after the issuance of a judgment by this Court allowing States to prohibit abortion. See Planned Parenthood Great Nw. v. Idaho, 522 P.3d 1132, 1152 (Idaho 2023). After this Court's decision in Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228 (2022), "the previously dormant [Section 18-622] was triggered and later went into effect on August 25, 2022." Planned Parenthood, 522 P.3d at 1158.

B. Proceedings Below

1. On August 2, 2022, the United States filed this suit against Idaho, arguing that Section 18-622 is preempted to the extent it directly conflicts with EMTALA. D. Ct. Doc. 1, at 15-16 (Aug. 2, 2022). The United States sought a preliminary injunction, and the district court permitted the Idaho Legislature to permissively intervene for the purpose of "presenting evidence and arguments" related to the preliminary-injunction motion. D. Ct. Doc. 27, at 1 (Aug. 13, 2022); see id. at 17-18.[3]

[3] The Legislature later renewed its motion to intervene as of right, D. Ct. Doc. 105 (Oct. 4, 2022), but the district court denied that motion, D. Ct. Doc. 125, at 10 (Feb. 3, 2023). The Legislature's appeal from that denial is pending. See United States v. Idaho, No. 23-35153 (9th Cir. docketed Mar. 3, 2023). The Legislature did not separately move to intervene for purposes of appealing the order granting a preliminary injunction.

a. On August 24, 2022 -- the day before Section 18-622 took effect -- the district court granted the United States' motion for a preliminary injunction, determining that the United States is likely to succeed based on "basic preemption principles" and the extensive record evidence. Leg. Appl. App. 56a; see id. at 76a-77a.[4]

First, the district court determined that "it is impossible to comply with both statutes." Leg. Appl. App. 57a. "[W]hen pregnant women come to a Medicare-funded hospital with an emergency medical condition," the court explained, "EMTALA obligates the treating physician to provide stabilizing treatment," including "when the stabilizing treatment is an abortion." Id. at 40a, 57a. Idaho law, however, permits only those "abortions that the treating physician determines are necessary to prevent the patient's death." Id. at 58a-59a. EMTALA's stabilization requirement is "broader than" that, "on two levels": it requires care (i) "to prevent injuries that are more wide-ranging than death," and (ii) "when harm is probable, when the patient could 'reasonably be expected' to suffer injury." Id. at 59a.

Based on declarations from medical experts, the district court found that several conditions could require abortion care as stabilizing treatment under EMTALA in circumstances where such

[4] We cite the materials filed in docket 23A469 as "Leg. Appl." and "Leg. Appl. App." We cite the materials filed in docket 23A470 as "State Appl." and "State Appl. App."

care would be prohibited under Idaho law. Those conditions include:

- "uncontrollable uterine hemorrhage," which, absent abortion care, could "requir[e] hysterectomy" or result in "kidney failure requiring lifelong dialysis";
- an "infection after the amniotic sac surrounding the fetus has ruptured," which, absent abortion care, could lead to "sepsis"; and
- pre-eclampsia, which could result in the "onset of seizures" or "hypoxic brain injury."

Leg. Appl. App. 40a, 46a. When federal law "requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws." Id. at 57a.

Second, the district court concluded that Section 18-622 "'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" Leg. Appl. App. 62a-63a (citation omitted). "[E]ven if it were theoretically possible to simultaneously comply with both laws," Idaho's ban would frustrate EMTALA's "clear purpose * * * to establish a bare minimum of emergency care that would be available to all people in Medicare-funded hospitals." Ibid. The court explained that Section 18-622 would deter stabilizing abortion care because the necessary-to-prevent-death standard would often require, in an emergency situation, a "medically impossible" determination that "death is the guaranteed outcome." Id. at 67a (citation omitted). With criminal consequences riding on that "uncertain, medically complex" judgment, "[d]elayed care," "worse care," and "worse[]

patient outcomes" would follow -- frustrating EMTALA's purpose. Id. at 67a, 70a-71a.

Finding that the remaining equitable factors likewise favored the United States, the district court granted targeted relief, "restrain[ing] and enjoin[ing] the State of Idaho" from enforcing Section 18-622 "as applied to medical care" required by EMTALA. Leg. Appl. App. 76a.

b. Idaho and the Legislature moved for reconsideration in September 2022. D. Ct. Docs. 97 (Sept. 7, 2022), 101 (Sept. 21, 2022). The district court denied reconsideration on May 4, 2023, noting that the motions largely "rehash[ed] arguments previously presented or" raised new "arguments that * * * could have [been] raised earlier." Leg. Appl. App. 30a.

2. On July 3, 2023 -- two months after the district court denied reconsideration and on the last day on which an appeal could be filed -- the Legislature filed a notice of appeal. D. Ct. Doc. 138 (July 3, 2023). And although the preliminary injunction had been in effect for nearly 11 months, the Legislature moved the district court to stay the injunction. D. Ct. Doc. 140 (July 3, 2023). The Legislature did not offer an explanation for its delay, nor did it request an order by a date certain. When the district court did not rule on the stay request, the Legislature sought a stay in the Ninth Circuit on August 22, 2023, two weeks after filing its opening brief. C.A. Doc. 31. The State, meanwhile,

appealed the preliminary injunction, D. Ct. Doc. 136 (June 28, 2023), but never sought a stay from either the district court or the court of appeals.

3. On September 28, 2023, a panel of the Ninth Circuit issued a published order granting the Legislature's motion for a stay pending appeal. Leg. Appl. App. 11a. The panel concluded that the Legislature had "made a strong showing" that EMTALA does not preempt Section 18-622. Id. at 12a; see id. at 13a-18a.

The panel believed that Section 18-622 does not conflict with EMTALA because EMTALA "does not set standards of care or specifically mandate that certain procedures, such as abortion, be offered"; rather, in the panel's view, EMTALA's purpose is simply "to prevent hospitals [from] dumping indigent patients by either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized." Leg. Appl. App. 13a, 15a (citation omitted; brackets in original). But "even assuming that EMTALA did require abortions in certain, limited circumstances," the panel believed that EMTALA "would not require abortions that are punishable by section 622." Id. at 13a-14a.

The panel also concluded that Section 18-622 does not pose an obstacle to accomplishment of EMTALA's purpose. Congress enacted EMTALA not "to create a national standard of care for hospitals," the panel posited, 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." Leg. Appl. App. 19a (citation omitted). The Act's "limitations on abortion services" therefore "do not pose an obstacle to EMTALA's purpose because they do not interfere with the provision of emergency medical services to indigent patients." Id. at 20a. Concluding that the remaining equitable factors favored the Legislature, id. at 20a-23a, the panel granted the motion for a stay pending appeal, id. at 24a.

4. On October 10, 2023 -- less than two weeks after the panel's decision -- the Ninth Circuit granted the United States' request that the stay motion be reheard en banc, vacating the panel opinion and restoring the preliminary injunction. Leg. Appl. App. 5a. Three weeks later, the Legislature moved for an expedited ruling, asking for a decision by November 15. C.A. Doc. 71 (Nov. 1, 2023). On November 13, 2023, the en banc court denied the stay motion, but scheduled oral argument on the merits of the appeal for January 23, 2024. Leg. Appl. App. 2a-3a; C.A. Doc. 85. Four members of the en banc court noted that they would have granted the stay motion "for substantially the reasons set forth in the original three-judge motions panel order." Leg. Appl. App.3a.

ARGUMENT

An applicant for a stay pending appeal and certiorari must establish (1) a "fair prospect" of success on the merits, (2) a "reasonable probability" that the Court would grant review in the

first place, and (3) that it "would likely suffer irreparable harm absent the stay" and "the equities" otherwise support relief. Merrill v. Milligan, 142 S. Ct. 879, 880 (2022) (Kavanaugh, J., concurring); see Hollingsworth v. Perry, 558 U.S. 183, 190 (2010) (per curiam). Applicants have failed to satisfy any of those traditional requirements.

I. APPLICANTS HAVE FAILED TO ESTABLISH A LIKELIHOOD OF SUCCESS ON THE MERITS

The district court correctly recognized that Section 18-622 directly conflicts with EMTALA -- and is thus preempted -- in the narrow but important circumstances where (i) pregnancy termination is the appropriate stabilizing treatment for an emergency condition that threatens serious harm to the pregnant woman's health, but (ii) the doctor cannot determine that the treatment is "necessary" to prevent "death."

A. EMTALA Requires Hospitals To Offer Abortion Care When That Care Is The Necessary Stabilizing Treatment For An Individual's Emergency Medical Condition

1. EMTALA requires a Medicare-participating hospital, as a condition of eligibility, to offer and provide essential emergency care to all individuals who come to the hospital in need of such care:

> **(b) Necessary stabilizing treatment for emergency medical conditions and labor**
>
> **(1) In general**
>
> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has

> an emergency medical condition, the hospital must provide * * * --
>
> (A) 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[.]

42 U.S.C. 1395dd(b). The plain language of Section 1395dd(b) makes clear that a covered hospital violates EMTALA if an individual "come[s] to [the] hospital" with "an emergency medical condition" and the hospital fails to provide "[n]ecessary stabilizing treatment" --- that is, "such further medical examination and such treatment as may be required to stabilize the medical condition." And EMTALA specifies that the required treatment is the care "necessary to assure" against "material deterioration" of the individual's condition. 42 U.S.C. 1395dd(e)(3).

2. For certain medical emergencies, abortion care is the necessary stabilizing treatment. Congress expressly provided that a "pregnant woman" could be among the "individual[s]" experiencing an "emergency medical condition." 42 U.S.C. 1395dd(e)(1)(A)(i), (B). Various conditions can arise (or become exacerbated) during pregnancy and qualify as "emergency medical conditions" under EMTALA -- including infection, premature pre-term rupture of membranes, placental abruption, sepsis, pre-eclampsia, and eclampsia. Leg. Appl. App. 35a; see C.A. E.R. 188–217, 319–358 (physician declarations).[5]

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[5] We cite the State's record excerpts in the court of appeals as "C.A. E.R." and the Legislature's as "Leg. C.A. E.R."

In some cases, the pregnant patient will likely die absent termination of the pregnancy; in others, the patient will be at risk of irreversible injuries, such as limb amputation, coma, stroke, hysterectomy, or organ failure. Leg. C.A. E.R. 15; C.A. E.R. 188–217, 319–358. The conditions creating those risks constitute "emergency medical condition[s]" under EMTALA. 42 U.S.C. 1395dd(e)(1)(A). And under EMTALA, the treating physician could determine that the requisite stabilizing treatment for patients experiencing such conditions is pregnancy termination -- that is, that termination is the only care that would assure, within reasonable medical probability, that no material deterioration of the individual's condition is likely to result. Leg. Appl. App. 35a-36a. If so, EMTALA requires that such treatment be offered and provided upon informed consent. 42 U.S.C. 1395dd(b)(1)(A), (2).

Consistent with that straightforward application of the statutory text, courts have long recognized that abortion care can constitute the "required medical treatment" under EMTALA for certain "emergency medical conditions." California v. United States, No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008); see also, e.g., New York v. HHS, 414 F. Supp. 3d 475, 537-539 (S.D.N.Y. 2019); Morin v. Eastern Me. Med. Ctr., 780 F. Supp. 2d 84, 93-96 (D. Me. 2010); Ritten v. Lapeer Reg'l Med. Ctr., 611 F. Supp. 2d 696, 712-718 (E.D. Mich. 2009).

Practitioners have likewise understood that EMTALA's stabilization requirements encompass abortion care in certain

circumstances: namely, if a medical provider determines that such care is the requisite stabilizing treatment for a specific emergency medical condition. E.g., C.A. E.R. 323–324 (Declaration of Dr. Lee Fleisher) ("Based on my experience as a medical practitioner * * * I know that pregnant patients experience a number of medical conditions" for which the "appropriate stabilizing treatment" under EMTALA is abortion care); accord id. at 339–346 (Declaration of Dr. Emily Corrigan); id. at 349–352 (Declaration of Dr. Kylie Cooper); id. at 355–358 (Declaration of Dr. Stacy Seyb); see also St. Luke's Amicus Br. 5-10. The State's declarants, too, have recognized that -- at least where necessary to "save the life of the pregnant woman" -- "termination of the pregnancy" is clinically appropriate, and they have not disputed the necessity of providing such care under EMTALA. C.A. E.R. 253–254; see id. at 249–260.

Congress itself has likewise understood EMTALA to require such care. In the prominent and carefully negotiated section of the Affordable Care Act specifically addressing abortion and the Act's effect on other laws dealing with abortion, Congress included a provision specifying that "[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as 'EMTALA')." 42 U.S.C. 18023(d); see John Cannan, A Legislative History of the Affordable Care Act, 105 L. Lib. J. 131, 157, 167-168 (2013). That provision

further confirms -- in enacted statutory text -- that abortion can constitute required stabilizing care under EMTALA.

B. EMTALA preempts Section 18-622 Insofar As It Prohibits Stabilizing Treatment Required Under EMTALA

The district court correctly recognized that there are narrow but important circumstances where Section 18-622 conflicts with EMTALA. And the court correctly held that in those circumstances -- and only those circumstances -- Section 18-622 is preempted. As the Idaho Supreme Court recognized, the tailored scope of the preliminary injunction means that Section 18-622 "is still in effect to the extent it does not conflict with EMTALA" -- that is, in the vast majority of its potential applications. Planned Parenthood Great Nw. v. Idaho, 522 P.3d 1132, 1158 (Idaho 2023).

1. EMTALA makes clear that state laws that conflict with the Act are preempted: "The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. 1395dd(f) (emphasis added). Under black-letter principles of conflict preemption, "federal law must prevail," either "where 'compliance with both state and federal law is impossible,' or where 'the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."' Oneok, Inc. v. Learjet, Inc., 575 U.S. 373, 377 (2015) (citation and internal quotation marks omitted).

2. In some circumstances, Section 18-622 directly conflicts with EMTALA because it is impossible to comply with both laws. Under Idaho law, it is a felony to provide abortion care unless "necessary" to prevent the patient's "death." Idaho Code Ann. § 18-622(2)(a)(i) (2023) (emphasis added). But EMTALA expressly extends beyond lethal harms, requiring stabilizing treatment to avoid serious threats to a patient's "health," "organ[s]," and "bodily functions." 42 U.S.C. 1395dd(e)(1)(A). And EMTALA requires such care "when the patient could 'reasonably be expected' to suffer injury" in the absence of immediate medical attention, rather than when such care is "necessary." Leg. Appl. App. 59a (quoting 42 U.S.C. 1395dd(e)(1)(A)). As the district court found, pregnant patients arrive at emergency rooms in Idaho suffering from non-lethal conditions -- including infections, pre-eclampsia, or premature pre-term rupture of membranes -- for which pregnancy termination is the stabilizing care required to avoid grave harms like strokes, sepsis, and kidney failure. See pp. 7-8, supra. In such circumstances, EMTALA directs that the hospital "must provide" that treatment on the patient's consent, 42 U.S.C. 1395dd(b)(1) -- but Idaho law forbids it.

The district court likewise correctly concluded that by criminalizing stabilizing care in those circumstances -- and by requiring suspension of the provider's license -- Section 18-622 stands as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." Leg. Appl. App. 63a.

These threats have "a deterrent effect," id. at 65a, and obstruct Congress's purpose of ensuring that all individuals "receive adequate emergency medical care," Arrington v. Wong, 237 F.3d 1066, 1074 (9th Cir. 2001).

C. Applicants' Contrary Arguments Lack Merit

Applicants do not dispute that Section 18-622 prohibits abortion care unless necessary to save the life of the mother. Nor do they dispute that EMTALA expressly extends beyond lethal harms to encompass emergency conditions that seriously threaten a patient's health. But applicants nonetheless insist that Section 18-622 does not conflict with EMTALA. Most aggressively, they assert that EMTALA does not require any necessary stabilizing treatment -- whether abortion or anything else -- if that treatment is not authorized by state law. That novel construction contradicts EMTALA's unambiguous text, and applicants' various attempts to justify it are unpersuasive. Applicants' narrower theory -- that even if EMTALA does mandate critical emergency care, that care never includes pregnancy termination -- is wrong too: When abortion care is necessary to stabilize an emergency medical condition, EMTALA requires such care. And applicants' various other efforts to avoid the natural reading of EMTALA's text lack merit.

1. EMTALA requires hospitals to provide stabilizing treatment and preempts conflicting state law

In opposing the United States' motion for a preliminary injunction, applicants argued that the United States failed to show any meaningful conflict between EMTALA and Section 18-622 because EMTALA does not speak to abortion specifically and, to the extent EMTALA requires such care, "[m]any EMTALA abortions" would be "necessary to save the mother's life." D. Ct. Doc. 66, at 15 (Aug. 16, 2022); accord D. Ct. Doc. 65, at 3 (Aug. 16, 2022). In this Court, however, applicants principally advance a much broader theory, declaring that EMTALA does not require any necessary stabilizing treatment -- whether "abortion" or "any other treatment" -- if that treatment is not "authorized under state law." State Appl. 18. EMTALA, in applicants' view, simply ensures parity of treatment -- it requires "that hospitals treat indigent patients the same as they treat anyone else," id. at 13 -- "[b]ut it does not give patients a federal right to receive" any particular care in the emergency room, id. at 20; accord Leg. Appl. 15-20. Applicants' cramped view of EMTALA -- which no court has adopted -- cannot be reconciled with the statutory text and finds no support in EMTALA's history or the settled body of law interpreting the Act.

a. As explained above, see pp. 12-13, supra, EMTALA's text makes plain that it requires more than parity of treatment between

the indigent and insured; rather, EMTALA imposes a clear obligation on covered hospitals to provide essential care to "any individual" determined to have an emergency medical condition. Subsection (b) mandates that a covered hospital "must provide" "such treatment as may be required to stabilize the [individual's] medical condition." 42 U.S.C. 1395dd(b). And subsection (e) directs that a hospital must "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 occur. 42 U.S.C. 1395dd(e)(3)(A). Construing EMTALA as applicants urge -- to prohibit only "patient dumping" -- would "directly conflict[] with the plain language of EMTALA" by permitting covered hospitals to provide "treatment that would allow [an individual's] condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals." In re Baby "K" (Three Cases), 16 F.3d 590, 595-596 (4th Cir. 1994) (Baby K). Nothing in the statute, moreover, suggests that state law somehow limits EMTALA's mandate to provide stabilizing treatment or its definition of the required care.

The State's own framing -- that "EMTALA's directive that hospitals provide 'such treatment as may be required to stabilize the medical condition' is best interpreted to mean such treatment among those treatments that are authorized under both state and federal law," Appl. 17 -- is telling. The emphasized words appear nowhere

in the text Congress enacted, and this Court "ordinarily resist[s] reading words or elements into a statute that do not appear on its face." Dean v. United States, 556 U.S. 568, 572 (2009) (citation omitted).

EMTALA's preemption provision -- which preempts any state law "requirement" that "directly conflicts" with EMTALA's "requirement[s]," 42 U.S.C. 1395dd(f) -- further refutes applicants' reading. If state law prohibits the only care that would assure, within reasonable medical probability, that no material deterioration of the individual's emergency medical condition is likely to result, Section 1395dd(f) expressly mandates that EMTALA controls to ensure the patient is stabilized.

Applicants' efforts to cabin EMTALA's preemptive effect are meritless. The Legislature, but not the State, argues that EMTALA's express preemption provision forecloses impossibility and obstacle preemption. See Leg. Appl. 19; but see State Appl. 14. But a reference to state law that is in "direct" conflict with federal law has long been understood to refer to general principles of conflict preemption. See, e.g., United Constr. Workers v. Laburnum Constr. Corp., 347 U.S. 656, 663 n.5 (1954) (referring to "direct and positive" conflict); Missouri, Kan. & Tex. Ry. Co. v. Haber, 169 U.S. 613, 623 (1898) (same); Sinnot v. Davenport, 63 U.S. (22 How.) 227, 243 (1859)) (same).

Applicants emphasize (Leg. Appl. 16; State Appl. 13) that Section 1395dd(f) provides that EMTALA "do[es] not preempt any State or local law" that does not directly conflict with the Act's requirements. But as the Ninth Circuit has explained, that provision simply ensures that state laws requiring emergency care beyond EMTALA's requirements are preserved. See Baker v. Adventist Health, Inc., 260 F.3d 987, 993 (2001) (Section 1395dd(f) preserves additional "state remedies," such as "a state law claim for medical malpractice"); see also, e.g., H.R. Rep. No. 241, 99th Cong., 1st Sess. pt. 1, at 4 (1985) (House Report) (explaining that EMTALA does "not preempt stricter state laws"). In contrast, if state law does directly conflict with EMTALA -- as relevant here, by prohibiting the very care necessary to ensure, within reasonable medical probability, that no material deterioration of the individual's condition is likely to result -- Section 1395dd(f) makes clear that EMTALA controls.

The State's remaining textual argument -- raised for the first time in the Ninth Circuit -- is likewise meritless. The State argues (Appl. 17-20) that care that is unauthorized by state law is not "within the staff and facilities available at the hospital," as required by subsection (b). But when Congress meant to incorporate state law in EMTALA, it said so expressly. See 42 U.S.C. 1395dd(d)(2)(A) and (B). By contrast, the language the State identifies plainly refers to the limits on care imposed by

a particular hospital's physical resources. Where a hospital and its personnel are fully qualified to provide the requisite stabilizing treatment, nothing in subsection (b)'s availability limitation suggests it is meant to obliquely override subsection (f)'s express preemption of state laws that conflict with EMTALA's requirements, including the Act's key stabilization obligation. Indeed, it would make little sense to interpret a federal emergency-services law with an express preemption provision -- enacted because state law at the time failed to ensure the provision of necessary emergency care, see Arrington, 237 F.3d at 1073-1074; 3 House Report at 5 -- to preserve state laws that prohibit that very care.

b. The State's emphasis on Congress's purpose in enacting EMTALA (Appl. 3-4, 22-24) is likewise unpersuasive. Although Members of Congress were certainly concerned about "patient dumping" -- that is, refusing treatment or transferring patients who cannot pay for care -- the plain text of the statute makes clear that Congress did not limit EMTALA in the manner the State posits. Congress did not, for example, extend protection only to the indigent; instead, the statute protects "any individual" who presents with an emergency condition. 42 U.S.C. 1395dd(b)(1). And Congress did not impose a non-discrimination requirement or forbid the denial of care based on inability to pay; instead, it explicitly required the hospital to "provide" such treatment "as may be

required to stabilize" the condition. Ibid. EMTALA's legislative history confirms the broad purpose that is apparent from its text: to provide an assurance of emergency care generally, through imposition of a minimum stabilization requirement for all patients with emergency conditions, not simply uniformity of treatment.[6]

c. Applicants' invocation of precedent fares no better. Courts of appeals have long recognized that "once an individual has been diagnosed as presenting an emergency medical condition," EMTALA requires the hospital to "provide that treatment necessary to prevent the material deterioration of the individual's condition." Baby K, 16 F.3d at 594; see, e.g., Moses v. Providence Hosp. & Med. Ctrs., Inc., 561 F.3d 573, 582 (6th Cir. 2009)

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[6] See H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 473 (1985) (adopting House's proposal that "all participating hospitals must * * * provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor"); 3 House Report at 5 (emphasizing EMTALA's goal of ensuring "adequate emergency room medical services."); 131 Cong. Rec. 28,569 (1985) (statement of Sen. Kennedy, EMTALA co-sponsor) (under EMTALA, "every patient who has a bonafide emergency must receive stabilizing care"); 131 Cong. Rec. at 28,568 (statement of Sen. Durenberger, EMTALA floor manager) (EMTALA "make[s] it clear that the Medicare Program will not do business with any institution which * * * turns its back on an emergency medical situation"); 131 Cong. Rec. at 28,569 (statement of Sen. Dole, EMTALA co-sponsor) (under EMTALA, a "patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient"); see also Arrington, 237 F.3d at 1073-1074 ("The 'overarching purpose of EMTALA is to ensure that patients, particularly the indigent and underinsured, receive adequate emergency medical care.'") (brackets and citation omitted).

("EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely"; it thus "requires that actual care, or treatment, be provided."), cert. denied, 561 U.S. 1038 (2010); Thomas v. Christ Hosp. & Med. Ctr., 328 F.3d 890, 893-896 (7th Cir. 2003) ("Once an emergency medical condition is detected, the hospital must act to stabilize the condition * * * before the patient can be transferred or released."); Burditt v. HHS, 934 F.2d 1362, 1368-1369 (5th Cir. 1991) (provider could not have complied with EMTALA "unless he provided treatment that medical experts agree would prevent the threatening and severe consequences of [patient's] hypertension while she was in transit").

By the same token, courts of appeals -- including in the decisions the State invokes (Appl. 4 n.1) -- have consistently recognized that "stabilizing treatment" cannot be read to require "only * * * uniform treatment" because such a reading "directly conflicts with the plain language of EMTALA." Baby K, 16 F.3d at 595-596; see, e.g., Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1259 n.3 (9th Cir. 1995); Correa v. Hospital San Francisco, 69 F.3d 1184, 1194 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996). In short, although EMTALA's "legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and

without insurance." Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991). "Rather, the Act's plain language unambiguously extends its protections to 'any individual' who seeks emergency room assistance." Ibid.[7]

Applicants do not identify any circuit precedent endorsing their view that state law can limit care otherwise required by EMTALA.[8] The Fourth Circuit expressly held otherwise in Baby K, concluding that "to the extent [state law] exempts physicians from providing care they consider medically or ethically inappropriate, it directly conflicts with the provisions of EMTALA that require

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[7] Insofar as some courts of appeals have stated that EMTALA's screening provision requires only uniform treatment among the indigent and insured, e.g., Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1138 (8th Cir. 1996) (en banc), that provision -- unlike the stabilization requirement -- does not impose an obligation on hospitals to provide medical care to achieve a specific treatment objective. See 42 U.S.C. 1395dd(a). Indeed, nearly every case applicants cite (Leg. Appl. 17; State Appl. 4 n.1) addresses the contours of EMTALA's screening provision, not the stabilization requirement.

[8] Neither of the decisions cited by the Legislature supports its claim (Appl. 17) that some circuits have concluded "EMTALA does not preempt state standards of medical care." In Bryan v. Rectors & Visitors, 95 F.3d 349 (1996), the Fourth Circuit recognized that EMTALA establishes a baseline duty to provide "stabilizing treatment for a patient who arrives with an emergency condition," but that "[o]nce EMTALA has met that purpose" by "ensuring that a hospital undertakes [such] treatment," "the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt." Id. at 351 (emphasis added). And in Hardy v. New York City Health & Hosp. Corp., 164 F.3d 789 (1999), the Second Circuit addressed whether EMTALA preempted a state procedural requirement (New York's notice-of-claim rule), not a state prohibition on necessary stabilizing care. Id. at 795.

stabilizing treatment to be provided." 16 F.3d at 597. By contrast, applicants primarily rely on decisions observing that EMTALA "is not intended to create a national standard of care for hospitals or to provide a federal cause of action akin to a state law claim for medical malpractice." Leg. Appl. 17 (quoting Baker v. Adventist Health, Inc., 260 F.3d 987, 993 (9th Cir. 2001)); State Appl. 4 n.1 (collecting cases). But while EMTALA does not establish a federal law of malpractice, it does require hospitals to provide the minimum level of care necessary to stabilize a patient's emergency medical condition. 42 U.S.C. 1395dd(e)(3)(A).[9] And if state law prohibits the requisite stabilizing care, it is state law -- not EMTALA -- that must give way.

2. EMTALA requires abortion care when necessary to stabilize an emergency condition

Applicants also assert that even if EMTALA does require covered hospitals to provide essential emergency care, regardless of state law, that care does not include abortion. State Appl. 3; see id. at 14-16, 20-4; Leg. Appl. 20-23. But applicants previously took the opposite position, acknowledging "circumstances

[9] Some courts of appeals -- including in decisions applicants cite -- have thus described EMTALA as establishing a cause of action for "failure to treat" where the hospital withholds the necessary stabilizing treatment, rather than a cause of action for medical malpractice. See, e.g., Gatewood, 933 F.2d at 1041; Hardy, 164 F.3d at 792-793; Summers, 91 F.3d at 1137; Vickers v. Nash Gen. Hosp., Inc., 78 F.3d 139, 142 (4th Cir. 1996).

when stabilizing treatment necessitated by EMTALA includes an abortion." State Response to P.I. Mot., D. Ct. Doc. 66, at 20; see id. at 15 ("The range of emergency room services subject to EMTALA is immense, and * * * may even include abortions."); Leg. Response to P.I. Mot., D. Ct. Doc. 65, at 9 (recognizing that "some serious medical condition[s] exist[] that require[] an emergency medical procedure under EMTALA, with that procedure ending the life of the preborn child"). Applicants' contrary argument in this Court is thus forfeited. It is also wrong.

a. Applicants argue that, because EMTALA does not expressly reference abortion, the statute does not mandate that such care be provided. State Appl. 15; Leg. Appl. 21. But as noted above, see pp. 12-13, supra, EMTALA mandates a generally applicable care objective: stabilization. It does not purport to specify the treatments necessary to achieve that objective in the wide range of circumstances covered by EMTALA. By not expressly specifying abortion care as a treatment that could satisfy its stabilization requirement, EMTALA treats such care the same as all other potential treatments for emergency medical conditions -- required if, and only if, the relevant medical professionals determine that such care constitutes the requisite stabilizing treatment. 42 U.S.C. 1395dd(e)(3); see Bostock v. Clayton County, 140 S. Ct. 1731, 1747 (2020) (there is no "such thing as a 'canon of donut holes,' in which Congress's failure to speak directly to a specific

case that falls within a more general statutory rule creates a tacit exception"). Indeed, as noted above, lower courts have long recognized that abortion care is among the treatments required as stabilizing treatment under EMTALA in certain circumstances. See p. 14, supra.

Applicants emphasize (State. Appl. 4, 14, 20; Leg. Appl. 21) that EMTALA mentions a specific form of stabilizing treatment in one circumstance: when a pregnant woman is in labor and "having contractions." 42 U.S.C. 1395dd(e)(1)(B); see 42 U.S.C. 1395dd(e)(3)(A) ("The term 'to stabilize' means, * * * with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)."). But by singling out "having contractions," EMTALA expands the definition of "emergency medical condition" to include labor, which otherwise might not satisfy subparagraph (e)(1)(A)'s definition, and requires a particular treatment. In identifying a specific stabilizing treatment in that one instance, Congress did not override EMTALA's general stabilization obligation -- or preclude any other necessary stabilizing treatment. See Cherukuri v. Shalala, 175 F.3d 446, 449-450 (6th Cir. 1999) (explaining that the definition of "stabilized" is "purely contextual or situational").

b. Applicants further argue (State Appl. 20; Leg. Appl. 22-23), echoing the motions panel, Leg. Appl. App. 14a, that EMTALA's references to an "unborn child" necessarily exclude abortion care

from EMTALA's express mandate to provide necessary stabilizing treatment. Applicants did not raise that argument in their briefs opposing a preliminary injunction, and it is wrong.

EMTALA's duties -- whether screening, stabilization, or transfer -- run to the "individual" seeking care. 42 U.S.C. 1395dd(a), (b)(1), and (c)(1). A hospital's screening obligation arises when an "individual" "comes to the emergency department" and a request for examination or treatment "is made on the individual's behalf." 42 U.S.C. 1395dd(a). A hospital's obligation to offer stabilizing treatment arises if it determines that "the individual has an emergency medical condition." 42 U.S.C. 1395dd(b)(1). The "individual" must be informed of risks and benefits and can give "informed consent to refuse such examination and treatment." 42 U.S.C. 1395dd(b)(2). And EMTALA restricts transfer "until [the] individual [is] stabilized." 42 U.S.C. 1395dd(c) (emphasis omitted); 42 U.S.C. 1395dd(c)(1) (restricting transfer "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized").

An "individual" is defined in the Dictionary Act to "include every infant member of the species homo sapiens who is born alive at any stage of development." 1 U.S.C. 8(a); see 1 U.S.C. 8(b) (defining "born alive"); see also United States v. Adams, 40 F.4th 1162, 1170 (10th Cir. 2022) (collecting cases interpreting Section 8 to exclude fetuses). And when EMTALA addresses the situation in

which an individual requiring emergency medical treatment is pregnant, EMTALA carefully distinguishes between "the individual" (denoting the "pregnant woman") and "her unborn child." 42 U.S.C. 1395dd(e)(1)(A)(i). Accordingly, in the context of emergency medical conditions arising during a pregnancy, the individual to whom EMTALA creates obligations -- and allows to choose whether to proceed with treatment -- is the pregnant woman.

EMTALA's references to an "unborn child" do not alter that conclusion. Three of those references address possible harm to an "unborn child" only when considering transfer of a pregnant individual in labor. 42 U.S.C. 1395dd(c)(1)(A)(ii), (c)(2)(A), and (e)(1)(B)(ii). The statute thus sensibly requires hospitals to consider risks to the health of an "unborn child" in determining whether the hospital may permissibly transfer an individual in labor before delivery. But those provisions say nothing about whether the statute establishes discrete obligations regarding an "unborn child" where a continued pregnancy poses a serious threat to the mother's life or health.

Applicants likewise misapprehend EMTALA's reference to an "unborn child" in Section 1395dd(e)(1)(A)(i). As originally enacted, EMTALA's definition of "emergency medical condition" did not account for the health of a pregnant patient's fetus. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 166 (42 U.S.C. 1395dd(e)(1)(A) (1988))

("placing the patient's health in serious jeopardy"). At the time, any risks to the "unborn child" were relevant only to determining whether a patient was in "active labor." Ibid. (codified at 42 U.S.C. 1395dd(e)(2)(C) (1988)). Thus, if a pregnant woman who was not in labor came to an emergency room with a medical condition that jeopardized the health of her fetus -- but not yet her own health -- the hospital was arguably under no obligation to offer her stabilizing treatment.

Congress amended the definition of "emergency medical condition" three years later to its current form, Consolidated Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h), 103 Stat. 2248 (1989), expanding the circumstances when a pregnant individual can be considered to have an "emergency medical condition" to include conditions that might threaten the health of the "unborn child," but not necessarily that of the pregnant individual. 42 U.S.C. 1395dd(e)(1)(A)(i). The amendment "[p]rovide[s] that 'emergency medical condition' also applies to a condition that places in serious jeopardy the health of the woman or her unborn child." H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess., at 838 (1989) (emphases added). But this insertion did not alter EMTALA's basic operation: what must be stabilized is the "medical condition," 42 U.S.C. 1395dd(b)(1)(A), of the "individual," 42 U.S.C. 1395dd(b)(1), (c), and (e)(1)(A)(i). And under subsections

(a), (b), and (c), a hospital's affirmative duties under EMTALA still run to the pregnant "individual."

Even if there were a conflict between independent statutory obligations to a pregnant "individual" and her "unborn child," EMTALA makes clear that it is for the pregnant woman, not state law, to decide how to proceed in that circumstance. Under paragraph (b)(2), if the pregnant individual is experiencing an emergency medical condition, the individual must be offered the necessary stabilizing treatment for that condition and informed of the risks and benefits. 42 U.S.C. 1395dd(b)(2). Then "the individual (or a person acting on the individual's behalf)" must decide whether to consent to or refuse the treatment. Ibid. EMTALA thus contemplates that it is the pregnant woman who must weigh the risks to herself and to her fetus and decide whether to continue a dangerous pregnancy.

Importantly, when Congress intends to create special rules governing abortion or excluding abortion care from otherwise-applicable rules, it does so explicitly. See, e.g., 10 U.S.C. 1093; 20 U.S.C. 1688; 22 U.S.C. 5453(b), 7704(e)(4); 25 U.S.C. 1676(a); 42 U.S.C. 238n, 280h-5(a)(3)(C), 300a-6, 300a-7, 300a-8, 300z-10(a), 1397ee(c)(7)(A), 2996f(b)(8), 12584a(a)(9). Indeed, the same legislation proposing the provisions that became EMTALA proposed another program that, unlike EMTALA, did expressly exclude abortion. Compare the Deficit Reduction Amendments of 1985, H.R.

3128, 99th Cong. § 124 (Sept. 11, 1985) (language that became EMTALA), with § 302(a) (excluding abortion from a different program's authorized activities). But Congress did not include such language in EMTALA, underscoring that Congress did not intend to exclude abortion care from EMTALA's stabilization mandate.

3. Applicants provide no reason to depart from the statutory text

Applicants' scattershot appeals to sources outside EMTALA provide no support for either of their theories.

a. Applicants invoke a separate provision of the Medicare Act, 42 U.S.C. 1395, to argue that EMTALA cannot require essential emergency care. State Appl. 16-18; Leg. Appl. 18-19. But applicants forfeited reliance on Section 1395 by failing to make this argument -- or even cite Section 1395 -- in opposing the motion for a preliminary injunction.

In any event, Section 1395 is entirely consistent with the district court's plain-text interpretation of EMTALA. Section 1395 states that "[n]othing in this subchapter 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. EMTALA's stabilization obligation was enacted by Congress, not imposed by a "Federal officer or employee," making Section 1395 inapplicable on its face.

Moreover, Section 1395 is entirely consistent with EMTALA's requirement that hospitals offer stabilizing medical treatment when medically necessary. As explained above, see pp. 28-29, supra, EMTALA mandates a care objective -- requiring treatment "necessary to assure * * * that no material deterioration of the condition is likely to result," 42 U.S.C. 1395dd(e)(3)(A) -- but does not specify particular treatments to achieve that objective. The meaning of "stabilized" is "purely contextual or situational," "depend[ing] on the risks associated with" a particular case and "requir[ing] the transferring physician, faced with an emergency, to make a fast on-the-spot risk analysis." Cherukuri, 175 F.3d at 449-450; accord Baby K, 16 F.3d at 595-596. And alleged violations of EMTALA, consistent with subsection (b)'s focus on "reasonable medical probability," have long been judged against medical professional standards and "sound clinical" judgment. See, e.g., Centers for Medicare & Medicaid Servs., EMTALA Physician Review Worksheet (issued Feb. 20, 2015), https://perma.cc/434U-7TUE.

By contrast, state laws that bar the provision of abortion care when it constitutes the necessary stabilizing treatment under EMTALA interfere with doctors' ability to exercise their medical judgment and respond to emergency medical conditions of pregnant women, with potentially disastrous consequences for those individuals. See pp. 16-18, supra. Nothing in Section 1395 nullifies EMTALA's stabilization requirement or preemption provision -- or

gives States the prerogative to deny pregnant women emergency care in hospitals receiving funds under Medicare. Far from authorizing interference by federal officials with the practice of medicine, the injunction preserves physicians' ability to identify and provide necessary stabilizing treatment.

The State, but not the Legislature, also makes passing references to an appropriation rider known as the Hyde Amendment, which restricts federal funding for certain (but not all) abortion care. See Consolidated Appropriations Act of 2022, Pub. L. No. 117-103, Div. H, Tit. V, §§ 506-507, 136 Stat. 496 (excepting abortion care where "the pregnancy is the result of an act of rape or incest" and where the woman is "in danger of death unless an abortion is performed"). Here again, the State forfeited this argument by failing to raise it in the preliminary-injunction briefing. In any event, the Hyde Amendment's funding restriction does not reference -- let alone purport to limit -- the scope of EMTALA's stabilizing obligation.

b. Departing from statutory text altogether, applicants invoke assorted constitutional provisions and background principles to argue that EMTALA cannot be interpreted consistent with its plain text. Those arguments, too, are meritless.

Applicants assert (State Appl. 14-15; Leg. Appl. 30-31) that the district court's construction of EMTALA violates the Spending Clause. But EMTALA reflects Congress's "broad power under the

Spending Clause" to "set the terms on which it disburses federal funds." Cummings v. Premier Rehab Keller, P.L.L.C., 142 S. Ct. 1562, 1568 (2022); 42 U.S.C. 1395cc(a)(1)(I)(i) (establishing compliance with EMTALA as a condition of Medicare payment). The only time this Court has found improper "coercion" in a spending program was in the Medicaid context -- which, unlike Medicare, involves funds provided directly to States -- when the Court concluded that States were forced to adopt new spending programs or lose federal funding (worth "over 10 percent of a State's overall budget") for existing programs. NFIB v. Sebelius, 567 U.S. 519, 580-585 (2012) (plurality opinion). Here, however, each hospital's participation in Medicare is voluntary. That EMTALA requires such participating facilities to provide essential emergency care is not a "weapon[] of coercion, destroying or impairing the autonomy of the states," but rather a targeted and "appropriate condition[]" attached to a federal "spending program[]" for hospitals, requiring those hospitals that have emergency departments to furnish a minimum level of care to individuals who present with emergency medical conditions. Id. at 579 (plurality opinion).

That the emergency care required under EMTALA may include abortion -- when that care is necessary to stabilize the emergency condition -- does not alter that conclusion. In Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228 (2022), this Court "returned" "the authority to regulate abortion * * * to the

people and their elected representatives," id. at 2279, which includes "their representatives in the democratic process in * * * Congress," id. at 2309 (Kavanaugh, J., concurring). Those representatives in Congress enacted EMTALA, which requires emergency departments to offer essential emergency care, including pregnancy termination when that is the necessary treatment, see pp. 12-16, supra -- and unequivocally preempts "any" state law that "directly conflicts" with that requirement. 42 U.S.C. 1395dd(f).

For similar reasons, applicants err in invoking the Tenth Amendment. State Appl. 13, 16; Leg. Appl. 26, 28-30. There can be no violation of the Tenth Amendment where, as here, "Congress act[ed] under one of its enumerated powers" in enacting EMTALA. New York v. United States, 505 U.S. 144, 156 (1992). This case fits the classic model of preemption: EMTALA's stabilization requirement "imposes restrictions or confers rights on private actors," Idaho's ban on such care "imposes restrictions that conflict with the federal law," and "therefore the federal law takes precedence and the state law is preempted." Murphy v. National Collegiate Athletic Ass'n, 138 S. Ct. 1461, 1480 (2018).[10]

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[10] These points address the State's contention that the district court lacked authority to enter the requested injunction because the government's suit invoked the Supremacy Clause. Appl. 12. The United States advances an equitable cause of action consistent with centuries of precedent. See Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 327 (2015) (referring to suits in equity "to enjoin unconstitutional actions by state and federal officers," a practice "reflect[ing] a long history of judicial

Applicants' invocation of Idaho's historic "police powers" disregards EMTALA's express preemption clause, 42 U.S.C. 1395dd(f). And applicants' reliance on Dobbs is again unavailing. Although Dobbs overruled Roe v. Wade, 410 U. S. 113 (1973), and Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U. S. 833 (1992), nothing in Dobbs suggested that the States' authority to regulate with respect to abortion is uniquely exempt from preemption by an otherwise valid federal statute. If Congress wishes to revisit EMTALA in light of States' greater authority to regulate abortion after this Court's decision in Dobbs, it is free to do so. But unless and until Congress acts, nothing in Dobbs provides any reason to depart from the plain text of EMTALA.

c. The Legislature's argument (Appl. 23-34) that the district court's "handling of EMTALA" "violated the major questions doctrine" likewise provides no reason to depart from the statutory text. That doctrine applies only when an "agency" asserts an "extraordinary grant of regulatory authority." West Virginia v. EPA, 142 S. Ct. 2587, 2612-2613 (2022); see, e.g. FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 160 (2000) ("We are

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review of illegal executive action, tracing back to England"). And here, at a minimum, the United States may bring suit in its sovereign capacity to enforce, against state interference, the federal Medicare program's condition on hospitals' receipt of substantial federal funds. See, e.g., United States v. Washington, 142 S. Ct. 1976, 1983 (2022); Arizona v. United States, 567 U.S. 387, 393-394 (2012).

confident that Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion.") (emphasis added). Here, however, the United States seeks to enforce "policy decisions" made by "Congress * * * itself" in EMTALA. West Virginia, 142 S. Ct. at 2609 (citation omitted).

In any event, this case bears none of the hallmarks of the handful of "extraordinary cases" that this Court has held presented a marked incongruity between an agency's claimed authority and the history and context of the statutory provision that purportedly conferred it. West Virginia, 142 S. Ct. 2609. The asserted power is neither "transformative" nor "sweeping." Id. at 2608, 2610 (citation omitted). To the contrary, "healthcare facilities that wish to participate in Medicare and Medicaid have always been obligated to satisfy a host of conditions that address the safe and effective provision of healthcare." Biden v. Missouri, 142 S. Ct. 647, 652 (2022) (per curiam). And EMTALA's express requirement that such facilities provide essential emergency care is not framed in "vague," "cryptic," "ancillary," or "modest" terms, West Virginia, 142 S. Ct. at 2608-2610 (citation omitted); to the contrary, the stabilization requirement is the centerpiece of an important statute, enacted to ensure that all individuals receive essential emergency care from providers that receive federal funding under Medicare, see pp. 12-13, 23-24, supra.

Congress, moreover, would have had no reason to speak more "clearly," Leg. Appl. 23 (citation omitted), to ensure that the requisite emergency care could include abortion care where appropriate: At the time of EMTALA's enactment, after all, no State could have banned the abortions required by the statute. See pp. 37-38, supra. This Court's decision in Dobbs did not retroactively transform that straightforward application of EMTALA as enacted into a "major question," calling for a departure from the plain statutory text.

II. THE REMAINING EQUITABLE FACTORS WEIGH HEAVILY AGAINST INJUNCTIVE RELIEF

Applicants' request to stay the injunction should be rejected for the additional reason that they have not demonstrated irreparable harm or that the equities otherwise favor a stay.

A. Applicants' claim of irreparable harm is most obviously refuted by their own long and unexplained delay in seeking relief. See Beame v. Friends of the Earth, 434 U.S. 1310, 1313 (1977) (Marshall, J., in chambers) ("The applicants' delay in filing their petition and seeking a stay vitiates much of the force of their allegations of irreparable harm.").

The State, for its part, has never sought a stay, in any court, prior to this one -- nor has it attempted to justify that failure. See Sup. Ct. R. 23.3; Conforte v. Commissioner, 459 U.S. 1309, 1312 n.2 (1983) (Rehnquist, J., in chambers) ("Applicant's failure to seek a stay in the Court of Appeals provides an

alternative ground for denial of the stay," where applicant has identified no "extraordinary circumstances" to justify that failure.) (citation omitted).

The Legislature, for its part, eventually sought a stay in the courts below. But it has failed to explain its long delay in doing so. The district court granted the preliminary injunction on August 24, 2022. See p. 7, supra. The Legislature declined to immediately appeal, filed a motion for reconsideration, and for the next 11 months failed to seek a stay in district court pending a ruling on its reconsideration motion or pending appeal. See p. 9, supra.[11] Then, once the court denied reconsideration, the Legislature waited until the final day of the 60-day period allowed for an appeal before noticing its appeal and seeking a stay in the district court. Ibid. In the court of appeals, the Legislature did not move for a stay until August 22, 2023 -- nearly a year after the injunction issued. Ibid. In declining to seek a stay altogether (the State), and in delaying again and again in seeking interim relief (the Legislature), applicants have made clear that their claims of irreparable harm are unsubstantiated.

Applicants' irreparable-harm arguments are also unpersuasive even on their own terms. Applicants do not suggest that the injunction inflicts any concrete injury on the State itself (let

[11] In fact, the Legislature joined the State's request to "stay issuance of a decision" on the pending reconsideration motion in order to allow supplemental briefing on the effect of Planned Parenthood, 522 P.3d at 1158. See D. Ct. Docs. 120, 121.

alone the Legislature); instead, they rely almost entirely on the injury a State suffers when the implementation of one of its statutes is enjoined. But that principle, while ordinarily sound, does not extend to statutes preempted by federal law. A State has no legitimate interest in enforcing a statute that must give way under the Supremacy Clause. That is particularly true here, where the district court enjoined Section 18-622 only to the extent it is plainly preempted by EMTALA, and the State -- the only applicant responsible for enforcing Section 18-622 -- failed to seek a stay in the lower courts.

B. The harms to the government and public interest, which "merge" here, Nken v. Holder, 556 U.S. 418, 435 (2009), also tilt sharply against the stay. As noted, applicants argue that the district court has caused them irreparable harm by enjoining the implementation of a state statute. By the same logic, however, staying the injunction would cause the United States irreparable harm by frustrating the operation of EMTALA. The Supremacy Clause determines how to balance those competing harms: The harm caused by the frustration of federal law (which is the supreme law of the land) necessarily outweighs any harm caused by an injunction barring implementation of a conflicting state law (which is not).

If the injunction were stayed, moreover, Section 18-622 would cause serious, tangible harms to the United States and to the public. Federal funding would no longer guarantee access to essential emergency care required by EMTALA, depriving the

government of the benefit of its bargain. C.A. E.R. 363–364; id. at 367–368 (noting over $3 billion in Medicare funding to Idaho hospitals over FY2018-2020). And allowing the preempted aspects of Idaho's law to take effect overnight, would, as the district court found, "threaten severe, irreparable harm to pregnant patients in Idaho." Leg. Appl. App. 74a. As documented in multiple provider declarations submitted to the district court, a stay would increase the risk that pregnant patients will face irreversible injuries, such as strokes, amputations, hysterectomies, and organ failure, that could have been prevented with appropriate emergency care. See pp. 7-8, 14, supra; see also, e.g., C.A. E.R. 341-342 (Corrigan Decl.) (describing recent patient suffering from preterm premature rupture of membranes, who, absent abortion care, would likely have "developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb amputations"). If a stay issues, physicians will be placed in an impossible position, unable to provide "medically necessary" care and "put[ting] the health of Idaho women at significant risk." C.A. E.R. 345-346.

A stay, moreover, is meant "simply [to] suspend[] judicial alteration of the status quo." Nken, 556 U.S. at 429. Here, the injunction itself preserves the status quo because it issued before Section 18-622's effective date and, other than the two weeks following the panel's order, the injunction has been in place continuously since Section 18-622 took effect.

III. CERTIORARI BEFORE JUDGMENT IS UNWARRANTED

In the alternative, the State, but not the Legislature, asks (Appl. 27-29) the Court to treat its application as a petition for a writ of certiorari before judgment. Review by this Court if the Ninth Circuit affirms the preliminary injunction -- much less certiorari before judgment -- is not warranted.

The district court's decision is correct and consistent with an unbroken line of appellate cases construing EMTALA. See pp. 24-27, supra. The State cannot show that the district court's decision conflicts with any decision of this Court or a court of appeals. No court of appeals has yet definitively ruled on EMTALA's interaction with state-law prohibitions on abortion -- the specific question presented by these applications. Cf. Texas v. Becerra, 623 F. Supp. 3d 696 (N.D. Tex. 2022) (enjoining HHS from enforcing guidance reiterating providers' obligation under EMTALA to provide emergency abortion care), appeal pending, No. 23-10246 (5th Cir.). And the broader conflict the State asserts regarding EMTALA's preemptive effect does not exist. See pp. 26-27, supra. That applicants failed to raise many of the arguments they now urge when opposing the United States' motion for a preliminary injunction makes review at this juncture particularly unwarranted.[12]

[12] In its brief opposing the motion for a preliminary injunction (D. Ct. Doc. 66), the State did not assert the broader theory it urges here -- that EMTALA does not require any necessary stabilizing treatment if that treatment is not "authorized under state law." Nor did it argue that EMTALA's "unborn child"

The case would therefore not warrant certiorari even had the court of appeals already affirmed the district court's injunction. That the State seeks to skip the step of first receiving a decision from the court of appeals, and instead requests certiorari before judgment, makes denial of certiorari all the more appropriate. This Court has made clear that certiorari before judgment "will be granted only upon a showing that the case is of such imperative public importance as to justify deviation from normal appellate practice and to require immediate determination in this Court." Sup. Ct. R. 11. The State has not made that showing.

The State asserts that certiorari before judgment is warranted because of alleged flaws in the Ninth Circuit's en banc process. But those criticisms are meritless. The Ninth Circuit did not "enjoin democratically passed legislation without providing a rationale," State Appl. 28; the district court enjoined Section 18-622 insofar as it conflicts with EMTALA, in a thoroughly

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references exempt abortion care from the Act's stabilization requirement. And the State did not invoke, among other things, Section 1395, the major questions doctrine, the Tenth Amendment, or the Hyde Amendment. The Legislature referenced some of these arguments, but with no analysis, see D. Ct. Doc. 65, at 13, presumably because the district court had permitted the Legislature to intervene only for the purpose of presenting evidence and factual arguments related to the preliminary-injunction motion, see p. 6, supra. In seeking a stay in this Court, the Legislature thus far exceeds the scope of intervention permitted by the district court's order -- and the Legislature never moved to intervene for the purpose of appealing the order granting a preliminary injunction. See Marino v. Ortiz, 484 U.S. 301, 304 (1988) ("The rule that only parties to a lawsuit, or those that properly become parties, may appeal an adverse judgment, is well settled.").

reasoned 39-page opinion -- followed by a second thorough opinion denying reconsideration. And although the State faults the en banc Ninth Circuit for denying the Legislature's pending stay motion without an opinion, the en banc court promptly ruled on that motion in response to applicants' request for an expedited ruling. See p. 11, supra. Nor did the Ninth Circuit delay further review -- it scheduled oral argument on the merits of applicants' preliminary injunction appeal in January 2024. Ibid. There is nothing unusual about an en banc court denying interim relief and issuing an expedited order to vacate the panel decision while setting the case for a full hearing on the merits. See Animal Legal Def. Fund v. Veneman, 490 F.3d 725, 727 (9th Cir. 2007) (Bybee, J., concurring); see also, e.g., 4th Cir. R. 35(c). And to the extent the State complains about the length of time that Section 18-622 has been enjoined, that is attributable to applicants' delay -- not the Ninth Circuit's -- given that the Legislature waited 11 months before seeking a stay, and the State never sought a stay at all. See pp. 9-11, supra.

CONCLUSION

The applications should be denied.

Respectfully submitted.

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