No. 23-726

In the Supreme Court of the United States

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

Petitioners,

v.

UNITED STATES,

Respondent.

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

BRIEF FOR PETITIONERS

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February 20, 2024

QUESTION PRESENTED

Whether EMTALA preempts state laws that protect human life and prohibit abortions such as Idaho's Defense of Life Act.

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Exec. Order No. 14076, 87 Fed. Reg. 42053 (July 8, 2022).....11, 42, 46

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A. Barrett, *Substantive Canons and Faithful Agency*, 90 B.U. L. Rev. 109 (2010).....54

A. Hamilton, *Report on the Subject of Manufactures* (1791) (Brown ed., 1827) 51

A. Scalia & B. Garner, Reading Law: The Interpretation of Legal Texts (2012).....31

Case of Proclamations (1610) 77 Eng. Rep. 1352, *reprinted in* 1 The Selected Writings and Speeches of Sir Edward Coke (Steve Sheppard ed., 2003) 47

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The Federalist No. 45 (Madison) (Jacob E. Cooke ed., 1961) 53

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Magna Carta (1215), *reprinted in* Magna Carta (David Carpenter ed., 2015) 47

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INTRODUCTION

For the country's first 200 years, Americans were free to address the "profound moral issue" of abortion in their respective States. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2240 (2022). Today, "Americans continue to hold passionate and widely divergent views on abortion, and state legislatures have acted accordingly." *Id.* at 2242. Idaho's Defense of Life Act is one such law. Idaho prohibits abortion except when necessary to prevent death or in cases of rape or incest. Congress, on the other hand, has remained mostly neutral. It has prohibited discrimination against physicians who do not perform abortions, outlawed coercing abortions, restricted abortion-related federal spending, and banned partial-birth abortion. Congress has otherwise deferred to the States.

But following this Court's decision in *Dobbs*, the White House directed federal agencies to expand access to abortion. The Department of Health and Human Services responded days later with a novel legal theory—that a condition of Medicare is "abortion care" irrespective of state law. This unprecedented suit against the State of Idaho followed. The Government's lone claim is that the Emergency Medical Treatment and Labor Act, or EMTALA, preempts Idaho's abortion law.

EMTALA is a statute that prohibits emergency departments in Medicare-participating hospitals from turning away indigent patients. 42 U.S.C. §1395dd. It requires screening patients and stabilizing emergency medical conditions before patients are transferred or

discharged. In 1989, Congress amended those requirements to embrace a pregnant woman's "unborn child." §1395dd(e)(1)(A)(i). EMTALA does not venture beyond those general terms to require specific medical treatments in thousands of emergency departments across the country. It leaves those decisions to the States and state malpractice law. Every court before *Dobbs* agreed: EMTALA does not displace state law regarding the practice of medicine. But after *Dobbs*, the Government insists that EMTALA is an abortion statute that displaces state law regarding abortion.

It is hard to imagine a tinier mousehole or a larger elephant than what the Government has contrived here. *See Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). EMTALA says nothing about abortion. Congress has not silently mandated abortions that it won't pay for, especially not in a statute amended to protect a pregnant mother's unborn child.

OPINIONS BELOW

The district court's preliminary injunction opinion and order is reported at 623 F.Supp.3d 1096 and reproduced at J.A.620-656. The district court's denial of reconsideration is reproduced at J.A.660-671. The Ninth Circuit's opinion granting the Legislature's stay motion is reported at 83 F.4th 1130 and reproduced at J.A.690-708. The Ninth Circuit's orders vacating the stay and granting rehearing *en banc* are reported at 82 F.4th 1296 and reproduced at J.A.709-711.

JURISDICTION

The Court has jurisdiction to review the preliminary injunction. 28 U.S.C. §§1254(1), 2101(e). After the district court denied motions to reconsider, the Legislature timely appealed. J.A.679-680; *see* 28 U.S.C. §1292(a)(1); Fed. R. App. P. 4(a)(4)(iv). The Legislature obtained a stay pending appeal, which the *en banc* Ninth Circuit then vacated. J.A.690-711. The Legislature sought a stay in this Court. The Court granted the stay application, construed the application as a petition for writ of certiorari before judgment, granted review, and consolidated this case with *Idaho v. United States*, No. 23-727.

STATUTORY PROVISIONS INVOLVED

Relevant federal statutory provisions are reprinted at App.1-30, and relevant state statutory provisions are reprinted at App.45-53.

STATEMENT OF THE CASE

I. Statutory History

A. EMTALA

1. In 1986, Congress amended the Medicare Act to add new requirements, known today as EMTALA. The amendment was part of the Consolidated Omnibus Budget Reconciliation Act (or COBRA). *See* Pub. L. 99-272, §9121(b), 100 Stat. 164-167 (codified as amended 42 U.S.C. §1395dd). COBRA never mentioned the word "abortion." And EMTALA itself confirmed that its "provisions … 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).

EMTALA applies only to Medicare-participating hospitals with emergency departments. §§1395cc(a)(1)(I), 1395dd(a). It ensures access to emergency services at such hospitals regardless of an individual's ability to pay. §1395dd(a), (h). Violations risk exclusion from Medicare, fines, and civil enforcement actions governed by "the law of the State in which the hospital is located." §1395dd(d)(1)-(2); *see* §1395cc(b)(2)(A).

EMTALA requires that if "any individual" comes to the emergency department, the hospital "must provide for an appropriate medical screening examination within [its] capability" to identify "emergency medical condition[s]." §1395dd(a). If that mandatory screening reveals an "emergency medical condition," then the hospital must provide "further medical examination and such treatment as may be required to stabilize" that condition before the hospital may "transfer" or discharge the patient, with some exceptions. §1395dd(b)(1)(A)-(B), (c)(1)-(2).

2. In 1989, Congress amended EMTALA to clarify how its requirements apply to a pregnant woman and "her unborn child" in the following four ways.

First, the amendment clarified that EMTALA's definition of "emergency medical condition" protects an "unborn child" whether or not a woman is in labor (amended text in bold):

(e)(1) The term "emergency medical condition" means—

(A) 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 ~~patient's~~ 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

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Pub. L. 101-239, §6211, 103 Stat. 2248 (42 U.S.C. §1395dd(e)(1)).

Second, the amendment clarified that the requirement "to stabilize" applies to an unborn child's emer-

gency medical condition too. *See* 103 Stat. 2248 (adding cross-reference to §1395dd(e)(1)(A)). The hospital must provide "such further medical examination and such treatment," "within the staff and facilities available at the hospital." §1395dd(b)(1)(A). 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 … .

§1395dd(e)(3)(A). For a woman in labor, she is "stabilized" after "the woman has delivered (including the placenta)." §1395dd(e)(3)(B). Beyond that, EMTALA does not require specific procedures, for example by requiring delivery by cesarian section.

Third, the amendment clarified how EMTALA's "transfer" rule applies to women in labor. *See* 103 Stat. 2246. Generally, hospitals cannot transfer patients whose "emergency medical condition[s] … ha[ve] not been stabilized," unless the benefits of transfer outweigh the risks or other exceptions are met. §1395dd(c)(1). The amendment added references to the "unborn child" so that physicians weigh benefits and risks to *both* the "individual" and, "in the case of labor, to the unborn child." 103 Stat. 2246 (§1395dd(c)(1)(A)(ii), (c)(2)(A)).

Fourth, the amendment added a nondiscrimination provision for specialized hospitals asked to accept transfers, including those with "neonatal intensive care units." 103 Stat. 2247-2248 (adding §1395dd(g)).

Such hospitals "shall not refuse to accept an appropriate transfer of an individual" who requires those "specialized capabilities," *id.*, such as an "extremely premature infant[] born alive before 24 weeks," Exec. Order No. 13952, 85 Fed. Reg. 62187, 62187 (Sept. 25, 2020).

EMTALA makes no reference to "abortion" or other medical procedures, consistent with the Medicare Act's proviso that federal officials will not "exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." §1395.

B. Idaho's Defense of Life Act

1. For Idaho's first 100 years, abortion was outlawed except when necessary to "save" or "preserve" the pregnant mother's life. Idaho's earliest territorial laws imposed criminal punishments for administering "any medicinal substance" or using "any instruments" for abortion, unless a physician "deems it necessary … to save her life." 1863-1864 Terr. of Idaho Laws 443. After statehood, Idaho re-enacted similar prohibitions, criminalizing abortion except when "'necessary to preserve her life.'" *Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1149-1152 (Idaho 2023) (collecting statutes).

After *Roe v. Wade*, 410 U.S. 113 (1973), Idaho enacted revised abortion statutes with language stating Idaho would reinstate abortion restrictions if *Roe* were overturned. *E.g.*, 1973 Idaho Sess. Laws 442-448. Idaho made that same promise again in 2020 when it enacted abortion restrictions to take effect 30 days after "any decision of the United States supreme

court that restores to the states their authority to prohibit abortion" or a constitutional amendment. 2020 Idaho Sess. Laws 827 (codified as amended Idaho Code §18-622). That day came in 2022. *See Dobbs*, 142 S. Ct. at 2243 ("It is time to heed the Constitution and return the issue of abortion to the people's elected representatives.").

2. Idaho's abortion law was set to take effect on August 25, 2022. Idaho Code §18-622(1)(a) (2020). The law subjected physicians to criminal penalties and suspension or revocation of their professional licenses if they intentionally terminated the life of "a developing fetus" after "fertilization" with some exceptions. §18-622(2) (2020); §18-604(1), (10) (2020); *see also* §18-622(4) (2020) (excluding "[m]edical treatment … that results in the accidental death of, or unintentional injury to, the unborn child"); *Planned Parenthood*, 522 P.3d at 1202-1203 (excluding "ectopic and non-viable pregnancies").

As initially conceived, the law allowed physicians to raise two affirmative defenses to justify an abortion. First, if "the abortion was necessary to prevent the death of the pregnant woman," then the abortion was permissible. §18-622(3)(a)(ii) (2020). Second, if the pregnant woman (or her parent or guardian) reported a rape or incest to appropriate authorities, then the abortion was permissible. §18-622(3)(b) (2020).

3. In July 2023, Idaho enacted the Defense of Life Act, amending its abortion law to its current form. 2023 Idaho Sess. Laws 298; *see Bradley v. Sch. Bd. of Richmond*, 416 U.S. 696, 711 (1974) ("[A] court is to

apply the law in effect at the time it renders its decision."). It remains a crime for physicians to perform or attempt abortions, §18-622(1), but instead of affirmative defenses and with revised definitions, the law today expressly permits the following conduct.

First, it remains lawful for physicians to provide "[m]edical treatment to a pregnant woman" even if it "results in the accidental death of, or unintentional injury to, the unborn child." §18-622(4).

Second, it remains lawful for physicians to treat women for miscarriages and ectopic or molar pregnancies. An "abortion" expressly is *not* "[t]he removal of a dead unborn child," "[t]he removal of an ectopic or molar pregnancy," "[t]he treatment of a woman who is no longer pregnant," or other circumstances where there is no "developing fetus." §18-604(1), (11); *see Planned Parenthood*, 522 P.3d at 1203 (interpreting definitions to require "*some* chance of survival outside the womb").

Third, a physician may intentionally terminate a pregnancy if, "in his good faith medical judgment and based on the facts known to the physician at the time," "the abortion was necessary to prevent the death of the pregnant woman." §18-622(2)(a)(i). But "[n]o abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself." *Id.* The physician, based on his or her subjective judgment, must also perform the abortion in a way that "provided the best opportunity for the unborn child to survive" (*e.g.*, pre-term delivery) unless that would "have posed a greater risk of death of the pregnant woman." §18-622(2)(a)(ii). These standards are

"subjective," "focusing on the particular physician's judgment," and do "not require *objective* certainty." *Planned Parenthood*, 522 P.3d at 1203. Nor does the exception demand "a particular level of immediacy, before the abortion can be 'necessary' to save the woman's life." *Id.*

Fourth, it is lawful for a physician to intentionally terminate a pregnancy "during the first trimester" when a pregnant woman (or her parent or guardian) reports to authorities that "she is the victim of an act of rape or incest." §18-622(2)(b).

4. In these ways, Idaho law parallels federal laws that expressly regulate abortion or abortion funding. Congress has made express findings about physicians' "medical, legal, and ethical duties … to preserve and promote life." *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). It has banned "partial-birth abortion" except when "necessary to save the life of a mother." 18 U.S.C. §1531(a). It has outlawed coercing anyone to undergo an abortion or discriminating against physicians who will not provide abortions for certain federal funding programs. 42 U.S.C. §§300a-7, 300a-8. And it generally has prohibited the use of federal funds to pay for abortions except "where the life of the mother would be endangered" or in cases of rape or incest. *See Harris v. McRae*, 448 U.S. 297, 301-303 (1980).

II. Procedural History

A. After *Dobbs*, the Government rewrites EMTALA to require "abortion care."

1. Two weeks after *Dobbs*, President Biden issued an executive order targeting the decision and directing the HHS Secretary to find ways "to protect and expand access to abortion care." Exec. Order No. 14076, 87 Fed. Reg. 42053, 42053 (July 8, 2022), App.24-30. Identifying EMTALA by name, the President instructed the Secretary to "consider[] updates to current guidance" regarding the statute's requirements. *Id.* at 42054.

Days later, the Secretary issued new EMTALA guidance. *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Services, Guidance Document QSO-22-22-Hospitals (July 11, 2022), App.31-44. The guidance requires "abortion" as "stabilizing treatment," "irrespective of state laws or mandates that apply to specific procedures":

> If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician **must** provide that treatment.

Id.

2. Weeks later, the Government deployed that novel theory by filing this suit against the State of Idaho. J.A.1-23. The Government's complaint contained one claim, "Preemption Under the Supremacy

Clause and EMTALA," and alleged that the Government was not "receiving the benefit of its bargain" for Medicare because Idaho law does not allow "abortion" as "stabilizing treatment." J.A.18, 20-21.

The Legislature and its leaders moved to intervene to defend state law. *See* Idaho Code §67-465(1). The district court "grant[ed] permissive intervention on a limited basis to allow the Legislature to present argument and evidence (including witnesses) in opposition to the United States' pending Motion for Preliminary Injunction." D.Ct. Doc. 27, at 1 (Aug. 13, 2022).[1]

B. The Government obtains a preliminary injunction.

1. The Government moved for a preliminary injunction less than three weeks before Idaho's abortion law was to take effect. Supporting declarations detailed the following possible emergency medical conditions. For every example offered, the Legislature's physicians testified that there was no conflict between EMTALA and Idaho law, because procedures described were either "life-saving procedure[s]" or otherwise not "abortion[s]." *E.g.*, J.A.564. The Legislature's physicians reached those conclusions based on decades of combined experience in obstetrics and emergency care including thousands of live births, crafting

[1] Later, the Legislature moved again to intervene as of right under Rule 24(a), given *Berger v. North Carolina State Conference of the NAACP*, 597 U.S. 179 (2022). The court denied the motion and noted the Legislature had been permitted permissive intervention. D.Ct. Doc. 125, at 10 (Feb. 3, 2023). The Legislature has separately appealed the court's application of *Berger*. *See United States v. Idaho*, No. 23-35153 (9th Cir.).

emergency room protocols for obstetric patients, and teaching appointments. J.A.544, 559-560.

Ectopic pregnancy and molar pregnancy: The Government's declarants said ectopic pregnancies and molar pregnancies were emergency medical conditions that could not be treated in Idaho. J.A.30-32, 374, 606-609. The Legislature's witnesses testified that defining treatment for these conditions as "abortions" is "inexcusable" and "medically baseless." J.A.547; *see* J.A.564-566, 581-582. Treating such conditions is not "abortion." *Planned Parenthood*, 522 P.3d at 1203; Idaho Code §18-604(1)(c).

Pre-eclampsia, eclampsia, and HELLP Syndrome: The Government's declarants asserted pre-eclampsia, eclampsia, or HELLP Syndrome could not be treated in Idaho. J.A.34-35, 361-362, 367-370. The Legislature's witnesses responded that these conditions present "life-threatening situation[s]" and can be "highly lethal"; they require "life-saving surgery" or "early delivery" in later stages of pregnancy, both of which Idaho law permits. J.A.547-548, 573-578; *see* J.A.567-568; *accord* J.A.514-515, 519-520, 522-523.

Sepsis: Premature rupture of membranes (PROM) can cause sepsis, which the Government's declarants said physicians could not treat in Idaho. J.A.35-37, 358-359, 373-374. The Legislature's witnesses responded that it would be "malpractice" not to treat premature PROM as life-threatening or a reason for "early delivery" in later stages of pregnancy. J.A.546-548; *see* J.A.571-572; *accord* J.A.515-516, 518.

Severe heart failure: One Government declarant hypothesized that Idaho physicians cannot treat a

pregnant woman with "severe heart failure" who requires "termination of the pregnancy." J.A.32-33. The Legislature's witnesses responded that life-saving treatment is allowed and clarified that "[m]aking terminating the pregnancy the primary objective could in fact be the worst first thing to do for the sake of the health of the mother," rather than transferring her to a hospital with "highly specialized equipment and capabilities." J.A.566-576; *see* J.A.547-548; *accord* J.A.513-514.

Placental abruption: The Government's declarants identified placental abruption and disseminated intravascular coagulation (DIC), which "creates a high risk of death for the mother due to the rapid loss of large volumes of blood," as conditions that could not be treated. J.A.360-361; *see* J.A.37-38. The Legislature's witnesses responded that life-saving treatment is clearly permissible, that sometimes "an immediate C-section is performed" after viability, and that "the baby was doomed to die due to the ruptured placenta." J.A.569-570, 572-573; *see* J.A.547-548; *accord* J.A.516-519.

The Legislature moved for a hearing to resolve these material factual disputes. The court refused. J.A.587-590.[2] The court concluded it was "impractical"

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[2] Most circuits require an evidentiary hearing unlike the Ninth Circuit. *Compare Arrowpoint Cap. Corp. v. Arrowpoint Asset Mgmt.*, 793 F.3d 313, 324 & n.11 (3d Cir. 2015) (collecting decisions from Second, Third, Fourth, Fifth, Sixth, Seventh, Eleventh, and D.C. Circuits), *with Int'l Molders' & Allied Workers' Local Union No. 164 v. Nelson*, 799 F.2d 547, 555 (9th Cir. 1986).

given the "complex factual dispute" and the short time before Idaho's law took effect. J.A.589-590.

2. The district court preliminarily enjoined Idaho's law "as applied to medical care required by [EMTALA]" one day before the law was to take effect. J.A.656. The court held EMTALA required "abortion care" as "stabilizing treatment" for pregnant women. J.A.638. It was "impossible to comply" with that requirement, according to the court, because Idaho's exceptions in its abortion law were too narrow. J.A.638-640. The opinion relied entirely on the Government's declarations, citing them nearly 40 times, while citing conflicting testimony of the Legislature's physicians' twice each to dismiss it as "a difference of opinion." J.A.640-641, 648 n.4. It was "immaterial" to the court whether Idaho law allowed treatment for the emergency conditions described in the Government's declarations. J.A.640.

Quoting EMTALA only in part, the court's order preliminarily enjoined the State and its officials from initiating criminal or disciplinary proceedings for abortions performed to avoid "'placing the health of' a pregnant patient 'in serious jeopardy,'" "'serious impairment to bodily functions,'" or "'serious dysfunction of any bodily organ or part.'" J.A.656 (quoting §1395dd(e)(1)(A)). The order removed all references to the "unborn child" in the same subsection. §1395dd(e)(1)(A)-(B). The court thus enjoined Idaho law based on its bowdlerized version of EMTALA.

3. The Idaho Legislature and Attorney General timely moved for reconsideration, asking the court to correct its order and otherwise account for EMTALA's

"unborn child" provisions. After a one-month sprint for the preliminary injunction proceedings, nine months passed before the court denied the reconsideration motions. In between, the Idaho Supreme Court affirmed the constitutionality of Idaho's abortion law, interpreted it to exclude ectopic and other non-viable pregnancies, and clarified its other parameters. *Planned Parenthood*, 522 P.3d at 1202-1205. The district court brushed aside that decision, concluding state law was still too narrow to satisfy EMTALA. J.A.660-671.

C. The Legislature obtains stays pending appeal.

1. The Legislature and Attorney General appealed. J.A.672-682. The Legislature sought a stay of the preliminary injunction pending appeal, which the Ninth Circuit granted. J.A.690-708.

The Ninth Circuit concluded there was no conflict between EMTALA and Idaho law. EMTALA, it reasoned, stops hospitals from "dumping indigent patients by either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized." J.A.698-699. It does not "require that a hospital provide whatever treatment an individual medical professional may desire." J.A.698. The court gave the example of a physician who thinks "an organ transplant is necessary to stabilize a patient's emergency medical condition." J.A.698. "EMTALA would not then preempt a state's requirements governing organ transplants." J.A.698.

The court reasoned in the alternative that, even if EMTALA did require specific procedures, "it would

not require abortions that are punishable by" Idaho law. J.A.697. The court rejected any "*implicit* duty" in EMTALA "to perform abortions," which would cause "'a material deterioration of the condition' of the child." J.A.698. And the court found "all the hypotheticals presented by the district court" have "been shown to satisfy section 622's 'life of the mother' standard, so the two laws would not conflict." J.A.702.

The court concluded that the Legislature showed irreparable harm and the balance of the equities favored a stay. J.A.704-707. The preliminary injunction undermined Idaho's "self-governance" and "strong interest in protecting unborn life." J.A.706. The court rejected that the stay would harm public health, given "Idaho's law expressly contemplates necessary medical care for pregnant women in distress." J.A.707.

2. The Government sought *en banc* review of the stay. The *en banc* court vacated the stay and reinstated the preliminary injunction pending its consideration of the appeal. J.A.709-711. Judges Callahan, Miller, Bress, and VanDyke dissented. J.A.711.

3. The Legislature and Attorney General filed stay applications in this Court. While the applications were pending, the Fifth Circuit affirmed that EMTALA does not mandate "abortion care," contrary to HHS's post-*Dobbs* guidance. *Texas v. Becerra*, 89 F.4th 529, 541-546 (5th Cir. 2024). This Court granted Petitioners' stay applications, construed them as petitions for writ of certiorari before judgment, and granted review.

SUMMARY OF ARGUMENT

I. EMTALA does not preempt Idaho's Defense of Life Act. EMTALA's express preemption provision is a non-preemption provision: no state law is displaced unless it "directly conflicts" with an EMTALA "requirement." 42 U.S.C. §1395dd(f). No EMTALA requirement demands specific medical procedures, consistent with the Medicare Act's proviso that it should not be "construed to authorize" federal officials to control "the practice of medicine or the manner in which medical services are provided." §1395.

A. EMTALA generally requires screening, stabilizing, and sometimes transferring patients to more suitable hospitals. Those requirements apply to an "unborn child" too. §1395dd(e)(1)(A)(i), (e)(3). But EMTALA does not dictate *how* to treat patients beyond those general requirements.

Even if EMTALA required specific procedures, there is no requirement to perform abortions that "directly conflicts" with Idaho law. §1395dd(f). Whatever emergency medical treatment EMTALA could require is consistent with the balance struck in Idaho law. Reading EMTALA to require something more would put it at war with its own terms—protecting the "unborn child"—and with other federal laws regulating abortion and abortion funding.

B. Nor does EMTALA cast a net of implied preemption contrary to its express terms. It is possible to comply with both state and federal law in ways consistent with Congress's objectives. EMTALA is a patient-dumping statute, not an abortion-access statute.

II. This is no ordinary case of statutory misconstruction. The Government's wayward reading of EMTALA is an intolerable federal power grab.

A. The Government's preemption theory contravenes the major questions doctrine. Congress has not given federal officials the power to preempt state abortion laws. EMTALA is not HHS's Trojan horse for nationwide abortion rules. EMTALA nowhere mentions abortion. Reading EMTALA as empowering HHS to displace state abortion laws defies the usual expectations of how Congress legislates and distorts the Constitution's separation of powers.

B. The Government's preemption theory also exceeds the limits of the Spending Clause. When Congress spends, as it does in the hundreds of billions for Medicare, it can put conditions on that spending, as it did with EMTALA. But spending conditions are not binding federal laws. Conditions are mandatory only for those who accept them voluntarily, knowingly, and revocably. But Medicare contracts are with hospitals, not with Idaho. Idaho never consented to the Government's novel requirement to let hospitals in the State perform abortions whenever HHS deems it necessary.

Spending conditions also cannot be ambiguous or coercive. But here, the Government threatens termination from Medicare as an outsized penalty for disobeying HHS's contrived abortion condition. That penalty would be wholly disproportionate to hospitals' duties under EMTALA. It would create a financial and public-health crisis in Idaho and the many other States that have returned to regulating abortion since *Dobbs*.

C. By exceeding its lawful authority under EMTALA, the Government undermines our federalist system. States are independent sovereigns, not units on a federal org chart. The people of Idaho retain the freedom to govern themselves regarding abortion. If Congress intends to encroach on state authority, it must do so with a clear voice and pursuant to its enumerated powers. Here, Congress has unambiguously *avoided* encroaching on Idaho's reserved powers.

The Government's extraordinary preemption theory lays the groundwork for federal control over abortion policy. But the theory is groundless. Congress has left the States free to govern themselves regarding abortion. Idaho is no exception. Idaho's Defense of Life Act is not preempted.

ARGUMENT

I. EMTALA Does Not Preempt Idaho's Defense of Life Act.

A. Idaho law does not "directly conflict[]" with any EMTALA "requirement."

Whether EMTALA preempts Idaho law begins with EMTALA's "plain wording." *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664 (1993). EMTALA's express preemption provision is better labeled a non-preemption provision:

> 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) (emphases added). Its meaning depends on the plain language of the provision itself, "the 'statutory framework' surrounding it," and "the 'structure and purpose of the statute as a whole.'" *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485-486 (1996). Particularly relevant here is that EMTALA is a condition of Medicare, and the Medicare Act begins with this proviso:

> Nothing 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.

These express provisions "defin[e] the pre-emptive reach" of EMTALA. *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 517 (1992). That reach is limited. While Medicare regulations have proliferated, *see Biden v. Missouri*, 142 S. Ct. 647, 652-653 (2022) (per curiam), Medicare does not purport to displace state laws regarding the practice of medicine, *see* §1395. EMTALA is no exception. EMTALA does not require specific medical treatments. Even if it did, there is no direct conflict with Idaho's abortion law. EMTALA itself protects an "unborn child" whose health is "in serious jeopardy." §1395dd(e)(1)(A)(i). Reading EMTALA to require abortions that Idaho prohibits puts it at war with its own terms and federal abortion laws.

1. EMTALA does not prescribe nationwide abortion rules.

No EMTALA requirement "directly conflicts" with Idaho's Defense of Life Act. §1395dd(f). EMTALA does not prescribe any specific medical treatment, let alone "abortion care," *contra* J.A.638. EMTALA prohibits Medicare hospitals from turning away indigent patients. §1395dd(a), (h). They must screen, stabilize, and sometimes transfer patients in the order EMTALA requires. §1395dd(a)-(c). But EMTALA is silent as to *how* hospitals must treat patients.

a. EMTALA throws three strikes against preemption.

First, the preemption provision is phrased in the negative: EMTALA does "not preempt … except … ." §1395dd(f). That syntax renders the provision a non-preemption clause, assuring readers that EMTALA generally will not preempt state law. *See, e.g.*, *De Veau v. Braisted*, 363 U.S. 144, 157 (1960) (plurality op.) (rejecting that state law was "impliedly pre-empted" by federal law when federal law contained "an express disclaimer of pre-emption … '[e]xcept as explicitly provided to the contrary'"); *see also, e.g.*, *Cal. Coastal Comm'n v. Granite Rock Co.*, 480 U.S. 572, 593 (1987).

Second, EMTALA contains a rare modifier, preempting only state requirements conflicting "directly" with EMTALA requirements. §1395dd(f).[3]

[3] Few other federal preemption provisions are limited to "direct" conflicts. *See* 7 U.S.C. §2156(h)(1); 15 U.S.C. §§1225, 1829; 16 U.S.C. §§544*l*(e)(5), 3507; 18 U.S.C. §§848, 927; 43 U.S.C. §1600g.

That qualifier distinguishes EMTALA from other statutes with broadly worded preemption provisions. *See, e.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-98 (1983) (considering ERISA's preemption provision covering any state law that "relates to" employee benefit plans).

Third, in the ordinary preemption case, this Court "'start[s] with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was 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)); *see Cipollone*, 505 U.S. at 518, 523. EMTALA's phrasing makes this no ordinary case. The text itself embraces the "strong presumption" that States have "primacy" over "matters of health and safety." *Medtronic*, 518 U.S. at 485.

EMTALA's narrower language was Congress's "deliberate choice," *Arizona v. United States*, 567 U.S. 387, 405 (2012), and the Court must give effect to each word, *see Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979); *Duncan v. Walker*, 533 U.S. 167, 174 (2001). EMTALA's default rule is that state law is *not* preempted.

b. EMTALA's remaining provisions confirm there is no direct conflict between EMTALA's requirements and Idaho law.

EMTALA speaks in general terms. It requires hospitals to conduct an "appropriate medical screening" within their "capability" for individuals who seek emergency medical treatment at a hospital participat-

ing in Medicare. §1395dd(a). That screening determines whether an "emergency medical condition" exists. *Id.* An "emergency medical condition" is one that, without "immediate medical attention," will place "the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy" or risks "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part." §1395dd(e)(1)(A)(i)-(iii). If a mother or her unborn child has an emergency medical condition, the hospital must "stabilize" the condition before transferring or discharging them, unless the benefits of transfer outweigh the risks or other conditions are met. §1395dd(b)(1), (c), (e)(3)-(4).

Critically, the duty "to stabilize" is not a freestanding requirement. It is connected to the screening requirement and requires treatment for the particular "condition" identified during screening. §1395(b)(1)(A), (e)(3)(A). It is limited by "the staff and facilities available at the hospital." §1395(b)(1)(A). And it is linked with EMTALA's transfer rule. 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." §1395dd(e)(3)(A) (emphasis added). Given that definition, the circuits are split about whether EMTALA continues to apply once patients are admitted.[4]

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[4] *Compare Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1167-1169 (9th Cir. 2002) (collecting cases), *with Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 582-583 (6th Cir. 2009), *cert. denied*, 561 U.S. 1038 (2010).

That stabilization requirement does not purport to impose nationwide rules for *how* patients must be stabilized. Even EMTALA's clarification about when a woman in labor is "stabilized" goes only as far as requiring "deliver[y] (including the placenta)." §1395dd(e)(3)(B). It does not prescribe the medical procedure—*e.g.*, delivery by cesarian section, or delivery with an epidural or without, or physiological or active delivery of the placenta, or other particulars that Congress left to hospitals and States. That silence is consistent with the Medicare Act's proviso that federal officials will not supervise "the practice of medicine or the manner in which medical services are provided." §1395.

EMTALA, accordingly, has no express "abortion care" requirement. It is silent on procedures generally, and abortions specifically, and lacks any "clear and manifest purpose" to preempt Idaho's "historic police powers." *Medtronic*, 518 U.S. at 485. Reading EMTALA to impose a nationwide abortion mandate would hide an elephant in the unlikeliest of mouseholes: a statute whose requirements include caring for an "unborn child." §1395dd(e)(1)(A)(i), (e)(3); *see Whitman*, 531 U.S. at 468. When Congress intends to regulate abortion, it says so. Part I.A.2.c, *infra*. EMTALA says nothing about abortion, leaving no basis to infer a nationwide rule "prevent[ing] the people's elected representatives from deciding how abortion should be regulated" within each State. *Dobbs*, 142 S. Ct. at 2257; *see Cipollone*, 505 U.S. at 517. Abortion laws no more "directly conflict[]" with an EMTALA "requirement," §1395dd(f), than other state laws regulating drug treatments, organ donation, or other medical

procedures. *See, e.g.*, Idaho Code §§39-3412, 39-3417 (regulating organ donation); N.Y. Penal Law §125.15(3) (criminalizing assisted suicide); Colo. Rev. Stat. §12-30-120(2)(a) (prohibiting "medication abortion reversal").

Indeed, the few times EMTALA speaks in more specific terms is when it clarifies that Medicare-participating hospitals have "dual stabilization requirements" extending to *both* a mother *and* "her unborn child." J.A.697. A hospital must stabilize a pregnant mother's emergency medical conditions as well as conditions placing "the health of … her unborn child[] in serious jeopardy." §1395dd(e)(1)(A)(i). Both must be "stabilized" with "medical treatment" so that "no material deterioration of the condition is likely to result from or occur during the transfer." §1395(e)(1)(A)(i), (e)(3)(A). Similarly, a woman in labor may not be transferred in ways that risk the health of "her unborn child." §1395dd(c)(1)-(2), (e)(1)(B), (e)(3)(A)-(B). EMTALA contains no "requirement" to end that unborn child's life. §1395dd(f).

c. The Government takes the more sweeping view, arguing that EMTALA requires whatever stabilizing treatment a physician deems necessary, which could include abortions at any stage of pregnancy to avoid impairing "bodily functions" or "bodily organ or part" dysfunction. §1395dd(e)(1)(A)(ii)-(iii); *see* U.S. Stay Resp. 14, 17. For the foregoing reasons, that argument ignores EMTALA's text.

EMTALA's preemptive scope is limited to its actual terms. Hospitals generally must "stabilize" patients within the limits of their "staff," "facilities," and

"capacity" before transferring them, §1395dd(b)(1)(A), (c)(2)(A), but EMTALA does not purport to displace state healthcare laws. Courts of appeals have "uniformly" recognized that EMTALA does not impose "a national emergency health care standard." *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc).[5]

The Fourth Circuit's case *In re Baby "K"*, 16 F.3d 590 (1994), is not to the contrary. There, the question was whether the hospital could withhold treatment for an infant's emergency medical condition—respiratory distress—because the infant had anencephaly and was likely to die. *Id.* at 596. Citing the stabilization requirement, the court held "EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception" for comatose or cancer patients with an underlying diagnosis likely to be fatal. *Id.* at 598.

No one disputes that Medicare-participating hospitals must treat emergency medical conditions. That includes treating the "unborn child" too. §1395dd(e)(1)(A)(i).

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[5] *See, e.g.*, *Bryant*, 289 F.3d at 1166; *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351-352 (4th Cir. 1996); *Harry v. Marchant*, 291 F.3d 767, 771-773 (11th Cir. 2002).

2. Even if EMTALA required specific procedures, there is no direct conflict with Idaho law.

Even if EMTALA required specific procedures for "stabilizing treatment," the Government's view of "abortion care" is not one of them. For in that world, EMTALA's requirement to stabilize the health condition of the "unborn child" remains. §1395dd(e)(1)(A)(i). Given that text, the Government cannot shoulder the heavy burden of identifying any direct conflict to "overcom[e] th[e] presumption" that the "state statute is valid." *Pharm. Rsch. & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 661-662 (2003).

a. The balance struck by Idaho presents no direct conflict with EMTALA.

Idaho allows abortions when "necessary to prevent the death of the pregnant woman," while still aiming to give "the best opportunity for the unborn child to survive." Idaho Code §18-622(2)(a)(i)-(ii). It also distinguishes "abortion" from "[m]edical treatment," even if "result[ing] in the accidental death of, or unintentional injury to, the unborn child." §18-622(4). Nothing in Idaho's abortion law interferes with physicians' treatment of miscarriages, ectopic pregnancies, and molar pregnancies. §18-604(1). And nothing in the statute requires "delayed" care, *contra* J.A.630. There is no "imminen[cy]" requirement, no "certainty" requirement, and no "medical consensus" requirement. *Planned Parenthood*, 522 P.3d at 1203-1204.

The Government has no argument that any state law requirement "directly conflicts" with EMTALA because EMTALA itself requires physicians to care for

both a mother and her unborn child. 42 U.S.C. §1395dd(e)(1)(A)(i), (f). The Government must instead argue that state law *implicitly* conflicts based on an *implied* duty to abort a mother's unborn child not only to save her life but also "to avoid serious threats to" her "'health,' 'organ[s],' and 'bodily functions.'" U.S. Stay Resp. 17 (quoting §1395dd(e)(1)(A)). Any such implied or indirect conflict will not do for preemption. EMTALA requires a *direct* conflict, §1395dd(f), and "matters beyond that reach are not pre-empted," *Cipollone*, 505 U.S. at 517.

b. The record also confirms that Idaho's Defense of Life Act does not directly conflict with EMTALA, even if EMTALA prescribed specific procedures.

The Government has no evidence that Idaho law prohibits medical treatment that EMTALA requires. *See* pp.12-14, *supra*. The Government's declarants testified about medical procedures where "death" was "imminent" and other "life-threatening" and "dire circumstances." J.A.356-57, 360; *see also, e.g.*, J.A.367-370, 373-376. The Legislature's witnesses responded in detail about how every proffered example could be treated with "lawful medical procedure[s]," some of which were not "abortion" and all of which involved life-threatening circumstances where "no informed, competent professional would second-guess the legality of the procedure" to save the mother's life. J.A.545-547; *see* J.A.512-526, 561-583; *see also* J.A.585 ("I would not prosecute any health care professional based on facts like those set forth in those declarations, and I believe no Idaho prosecuting attorney would do so.").

The Government has also mischaracterized lawful "[m]edical treatment" as "abortion." Idaho Code §18-622(4). Treating severe heart failure, ectopic pregnancies, molar pregnancies, and myriad other emergency medical conditions are not "abortions." *Planned Parenthood*, 522 P.3d at 1203. Dr. French—who has 38 years of medical experience, including in Idaho emergency rooms, and who has taught medical students across the country about all types of pregnancy complications—explained that "abortion" is not "the first line treatment" for medical emergencies. J.A.559-560, 563-564 (using example of emergency treatment for a gunshot wound to a pregnant woman's chest or abdomen).

And yet, the district court preliminarily enjoined Idaho law by assuming, without an evidentiary hearing, that the Legislature's witnesses were simply wrong. *See* J.A.640-641, 648 n.4. The court deemed it "immaterial" whether the Government's examples would comply with Idaho law. J.A.640. But that was precisely the Government's burden: to identify a direct conflict between EMTALA and presumptively valid Idaho law. *See Walsh*, 538 U.S. at 661-662. No example by the Government's declarants gets there. *See* pp.13-14, *supra*. The Government cannot now speculate, without evidence, that EMTALA might require "abortion care" in some heretofore unidentified circumstance short of life-threatening conditions when its own witnesses would not even go so far.

c. The Government's reading of EMTALA—requiring "abortion care" for "health" reasons that are not life-threatening, U.S. Stay Resp. 17—also conflicts

with other federal laws that, unlike EMTALA, actually do address abortion. Those federal laws strike the same balance as Idaho, permitting abortions or abortion-related funding when necessary to prevent death or in cases of rape and incest. Contrary to those laws, the Government's version of EMTALA would require abortions that, at best, Congress will not fund and, at worst, Congress has banned. Rather than create that conflict, "[i]t is this Court's duty to interpret Congress's statutes as a harmonious whole rather than at war with one another." *Epic Sys. Corp. v. Lewis*, 584 U.S. 497, 502 (2018); *see* A. Scalia & B. Garner, Reading Law: The Interpretation of Legal Texts 252-255 (2012). Even if EMTALA were "ambiguous," the Court would "construe it to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law." *W. Va. Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 100 (1991); *see FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("[T]he meaning of one statute may be affected by other Acts.").

EMTALA's silence is consistent with Congress's usual neutrality on abortion. Some federal statutes remain neutral by deferring to state law. The Freedom of Access to Clinic Entrances Act prohibits obstructing abortion clinics but states that nothing in that act "shall be construed … to interfere with the enforcement of State or local law regulating the performance of abortions or other reproductive health services." 18 U.S.C. §248(d)(4). Similarly, the Affordable Care Act allows States to "elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for

such prohibition." 42 U.S.C. §18023(a)(1); *see also* 42 U.S.C. §289g-1(b)(2)(A) (fetal tissue research permitted only if "the abortion was performed in accordance with applicable State law"); 42 U.S.C. §1396u-2(e)(1)(B) (exempting "abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services").

Other federal provisions ensure neutrality by prohibiting discrimination or coercion. Federal officials cannot discriminate against healthcare providers who do not provide abortions. *See, e.g.*, 42 U.S.C. §300a-7(c); *see also* Consolidated Appropriations Act, Pub. L. 117-328, §209, 136 Stat. 4880 (2022). Federal officials cannot require certain recipients of public health funds to perform abortions or otherwise "coerce" a woman "to undergo an abortion … by threatening that person with the loss of, or disqualification for the receipt of … [f]ederal financial assistance." 42 U.S.C. §§300a-7(b), 300a-8.

When Congress has taken a position, it has restricted abortions and abortion funding. In 1873, Congress passed the Comstock Act, prohibiting "use" of "the mails" for instruments or medicine "intended for producing abortion." Act of Mar. 3, 1873, ch. 258, 17 Stat. 598-599 (18 U.S.C. §§1461, 1462). In 2003, Congress banned "partial-birth abortion" where an unborn child is "partially delivered" and then "disarticulate[d] at the neck" or its skull "pierced" or "crush[ed]." *Carhart*, 550 U.S. at 139-140, 142. The only exception is for procedures "necessary to save the life of a mother whose life is endangered" by a "physical" condition. 18 U.S.C. §1531(a).

Since 1976, Congress has also generally prohibited the use of federal funds to pay for abortions. *See Harris*, 448 U.S. at 301-303. Exceptions to that general rule are narrow. The first Hyde Amendment contained an exception "where the life of the mother would be endangered if the fetus were carried to term." Pub. L. 94-439, §208, 90 Stat. 1434 (1976). That same restriction remained when Congress enacted EMTALA. *See* Pub. L. 99-178, §204, 99 Stat. 1119 (1985).

Similar federal funding restrictions bind HHS and other federal agencies today.[6] While those funding restrictions sometimes except abortions when a woman is "in danger of death" due to a "physical" condition, they do not except abortions for health issues beyond those life-saving measures.[7] Other HHS programs preclude abortion funding altogether. Federal funding cannot be used for family planning programs "where abortion is a method of family planning."[8] School-based health centers are ineligible for funding if they

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[6] *See* Pub. L. 117-328, §§202-203, 506-507, 613-614, 136 Stat. 4541, 4699, 4908 (2022) (Justice, HHS, Labor, Education, federal employee health benefits); 10 U.S.C. §1093 (Defense); 22 U.S.C. §2151b(f) (foreign assistance); 25 U.S.C. §1676 (Indian Health Service); Pub. L. 102-585, 106 Stat. 4947 (38 U.S.C. §1710 note) (Veterans Affairs). Congress has not yet passed an appropriations bill for HHS for fiscal year 2024. Pub. L. 118-35, 138 Stat. 3 (2024) (continuing resolution).

[7] Pub. L. 117-328, §507, 136 Stat. 4908; *see, e.g.*, Pub. L. 117-328, §§202, 614, 810, 136 Stat. 4541, 4699, 4723; 10 U.S.C. §1093.

[8] 42 U.S.C. §300a-6.

"perform abortion services," and other funding programs for suicide prevention and child health assistance cannot be used for abortions.[9]

The upshot is clear: Congress has struck the same balance as Idaho by allowing abortion or abortion funding necessary for life-endangering physical conditions. That Congress has "imposed the same type of restriction[s]" as Idaho "is surely evidence that Congress does not view such a restriction" under state law "as incompatible" with federal law. *De Veau*, 363 U.S. at 156 (plurality op.).

But the Government reads EMTALA to impliedly mandate abortions that Congress has expressly disapproved or refused to fund. By the Government's logic, EMTALA could require partial-birth abortions to protect "bodily functions" or "parts" if a physician so determines. 42 U.S.C. §1395dd(e)(1)(A)(ii)-(iii); *see* U.S. Stay Resp. 14. But the federal partial-birth abortion ban prohibits such abortions if not also "necessary to save the life of a mother." 18 U.S.C. §1531(a). By the Government's logic, EMTALA would require Medicare-participating physicians to perform abortions despite conscience objections. *Cf.* 42 U.S.C. §300a-7(c). And by the Government's logic, EMTALA would require abortions that the Government will not pay for (absent "danger of death" due to a "physical condition," or reported rape or incest). *See, e.g.*, Pub. L. 117-328, §§506-507, 613-614, 136 Stat. 4699, 4908.

This Court need not read EMTALA to say something "at war" with both federal and state abortion

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[9] *E.g.*, 42 U.S.C. §§280h-5(f)(1)(B), 290bb-36(i), 300z-10(a), 1397ee(c)(1), 1397jj(16).

laws. *Epic Sys.*, 584 U.S. at 502. There is no evidence of any such conflict. The statutes should be read "as a harmonious whole." *Id.*

B. EMTALA does not impliedly preempt Idaho law.

1. Given EMTALA's "express language," the Court need not look beyond EMTALA's text to decide whether it preempts Idaho law. *Cipollone*, 505 U.S. at 517; *see also Kansas v. Garcia*, 140 S. Ct. 791, 808 (2020) (Thomas, J., concurring) (rejecting "'purposes and objectives' pre-emption" as "rest[ing] on judicial guesswork"). But the Court at times has applied implied preemption tests even in cases involving express preemption language. *See Hillman v. Maretta*, 569 U.S. 483, 498 (2013); *Arizona*, 567 U.S. at 406. Even then, the conclusion is the same.

An implied preemption inquiry is still bounded by EMTALA's text and structure. "Implied preemption analysis does not justify a 'freewheeling judicial inquiry into whether a state statute is in tension with federal objectives,'" which "'would undercut the principle that it is Congress rather than the courts that pre-empts state law.'" *Chamber of Com. of U.S. v. Whiting*, 563 U.S. 582, 607 (2011) (plurality op.) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 111 (1992) (Kennedy, J., concurring in part and concurring in the judgment)). The Ninth Circuit, for example, has applied implied preemption principles to EMTALA. *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993). And as the Ninth Circuit's stay opinion illustrated, J.A.697-704, whatever the label, the ultimate question is whether Idaho law "conflict[s] with

the federal law." *Murphy v. NCAA*, 584 U.S. 453, 477 (2018). It does not.

Just as Idaho law does not directly conflict with federal law, Part I.A, *supra*, "compliance with both federal and state regulations is" not "a physical impossibility," *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-143 (1963). This case is not one where "federal law forbids an action that state law requires." *See Mut. Pharma. Co. v. Bartlett*, 570 U.S. 472, 486-487 (2013). There are no conflicting obligations between state abortion law and EMTALA. Part I.A, *supra*.

Nor does Idaho law impose an obstacle to Congress's "purposes and objectives." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 373 (2000). Whether such "obstacle" preemption exists "is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects." *Id.* Here, the courts of appeals agree that EMTALA was enacted in response to Congress's concerns that hospitals were "dumping" indigent patients, either by refusing to treat them or transferring them amid an emergency medical condition. *See Marshall v. E. Carroll Par. Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) (collecting cases). The statute "as a whole" addresses that concern. *Crosby*, 530 U.S. at 373. EMTALA begins with a promise that "any individual" who comes to the ER can have "an appropriate medical screening examination" within the hospital's "capability" and, if applicable, "stabilizing treatment" or "transfer" for an "emergency medical condition." §1395dd(a)-(c). It ends with a requirement that hospitals "not delay … screening" or "treatment" to ask

"about the individual's method of payment or insurance status." §1395dd(h). But it does not set national standards for specific medical procedures. Part I.A.1, *supra*.

If anything, the *Government's* arguments thwart Congress's evident objectives. EMTALA protects the "unborn child" and prohibits a hospital from refusing to provide medical "treatment" if necessary or "transfer" if appropriate to avoid placing the health of the "unborn child" "in serious jeopardy." §1395dd(b)(1), (e)(1)(A)(i). Across federal law, federal funds are not available for abortions except when necessary to save a mother's life, or in cases of rape or incest. Part I.A.2.c, *supra*. It should come as no surprise that EMTALA is not at war with those statutes. *See Epic Sys.*, 584 U.S. at 502.

For nearly 200 years until *Roe*, "each State was permitted to address" the "profound moral issue" of abortion "in accordance with the views of its citizens." *Dobbs*, 142 S. Ct. at 2240. EMTALA's text has not changed since this Court overruled *Roe*. EMTALA has nothing to say on the subject. "It is not the purpose of EMTALA to force hospitals to treat medical conditions using certain procedures" but instead "to prevent hospitals from neglecting poor and uninsured patients with the goal of protecting 'the health of the woman' and 'her unborn child.'" J.A.703-704 (quoting §1395dd(e)(1)(A)). Federal law does not preempt Idaho's Defense of Life Act.

II. The Government's Novel Preemption Theory Offends the Major Questions Doctrine and Exceeds Constitutional Limitations.

The Government's complaint rests on the lone theory that the Supremacy Clause empowers the Government to preempt Idaho law. But the Supremacy Clause does not, by itself, hold such power. *Murphy*, 584 U.S. at 477. "[P]ointing to the Supremacy Clause" alone "will not do." *Id.* The Government must identify what "power" it has to preempt. *Id.* Congress did not give the Executive Branch such power in EMTALA. Reading EMTALA to say otherwise offends the major questions doctrine and well-established limits for spending legislation. Exceeding those guardrails takes federal power beyond what the Tenth Amendment permits. The Government's view of EMTALA gets our federalist system backwards, supplanting Idaho's sovereignty without congressional or constitutional authority.

A. Construing EMTALA to require abortion offends the major questions doctrine.

The Government must identify "clear congressional authorization" when asserting power over "decisions of vast 'economic and political significance.'" *Utility Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014). In that instance, "something more than a merely plausible textual basis" is necessary. *West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (2022). Requiring a clear statement of congressional authority "addresses a particular and recurring problem: agencies asserting highly consequential power beyond what

Congress could reasonably be understood to have granted." *Id.* That rule of construction is rooted in "both separation of powers principles and a practical understanding of legislative intent." *Id.*

After all, a federal agency "literally has no power to act, let alone pre-empt the validly enacted legislation of a sovereign State, unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). Courts sometimes treat statutory ambiguity as "an implicit delegation from Congress to fill in the statutory gaps." *Brown & Williamson*, 529 U.S. at 159. But EMTALA's silence is not ambiguity. *See, e.g.*, *ICC v. Cincinnati, N.O. & T.P. R.*, 167 U.S. 479, 494-495 (1897). Any "reasonable interpreter would expect [Congress] to make the big-time policy calls itself" if it meant EMTALA to override state abortion laws. *Biden v. Nebraska*, 143 S. Ct. 2355, 2380 (2023) (Barrett, J., concurring).

1. Familiar hallmarks of the major questions doctrine are present.

The Executive Branch has declared "a fundamental revision of [a] statute" that HHS is tasked with administering, "changing it from one sort of scheme of regulation into an entirely different kind." *West Virginia*, 142 S. Ct. at 2612 (internal quotations and alterations omitted). Recasting EMTALA as an abortion mandate entails "political" and "economic" consequences that are "staggering by any measure." *Nebraska*, 143 S. Ct. at 2373.

Take the political implications. Congress's decades-long lawmaking on abortion would be supplanted by the Government's re-writing of EMTALA.

Despite the balance of federal and state prerogatives in federal law and the Constitution, HHS would have the final word on the availability of abortion in most hospitals nationwide. Twenty-two States have laws restricting abortion since *Dobbs*,[10] and neither the White House nor HHS approves. *See* App.24-44. But those policy calls are left to Congress and the States. There is no evidence Congress constructed EMTALA as an "ad hoc nullification machine" to displace state laws contrary to the White House's preferred abortion policy. *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 785 (1994) (Scalia, J., concurring in the judgment in part and dissenting in part). Yet the Government's preemption theory seeks that exact result.

By the Government's own account, the economic implications are no less significant. Violations of EMTALA risk exclusion from Medicare, the source of substantial federal funds for hospitals. *See* 42 U.S.C. §1395dd(d).[11] In 2022 alone, Medicare spending topped $944 billion.[12] Between 2018 and 2020, Idaho

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[10] Ariz. Rev. Stat. §36-2322; Ark. Code §5-61-304; Fla. Stat. §390.0111; Idaho Code §18-622; Ind. Code §16-34-2-1; Iowa Code §146E.2; Ky. Rev. Stat. §311.772; La. Stat. §40:1061; Miss. Code §41-41-45; Mo. Rev. Stat. §188.017; Mont. Code §50-20-109; Neb. Rev. Stat. §71-6915; N.C. Gen. Stat. §90-21.81B; N.D. Cent. Code §12.1-19.1-02; Okla. Stat. tit. 63, §1-745.5; S.C. Code §44-41-630; S.D. Codified Laws §22-17-5.1; Tenn. Code §39-15-213; Tex. Health & Safety Code §170A.002; Utah Code §76-7a-201; W. Va. Code §16-2R-3; Wyo. Stat. §35-6-123.

[11] *See* Letter from Secretary Becerra to Health Care Providers, at 2 (July 11, 2022), https://bit.ly/42FFGJ4 (Becerra Letter).

[12] *National Health Expenditure Fact Sheet*, CMS, https://bit.ly/3SSrIPU (last visited Feb. 19, 2024) (NHE Fact Sheet).

hospitals received $3.4 billion under Medicare, including $74 million for emergency care. J.A.385. Roughly one out of every five people in Idaho are enrolled in Medicare and depend on those hospitals.[13] Excluding those hospitals and cutting off that funding would create "calamitous consequences" for hospitals, Medicare enrollees, and the State. *Utility Air*, 573 U.S. at 321.

Given the vast "economic and political significance" of that newfound executive authority, the Government must identify "something more than a merely plausible textual basis" for the power it asserts under EMTALA. *West Virginia*, 142 S. Ct. at 2608-2609. It must show where EMTALA gives "clear congressional authorization" for HHS to compel Medicare-participating hospitals to perform abortions. *Utility Air*, 573 U.S. at 324.

That the Government has elected to pursue its new policy through litigation against the State only adds to the "unprecedented" and irregular transformation of EMTALA. *West Virginia*, 142 S. Ct. at 2612; *see, e.g.*, *Gonzales v. Oregon*, 546 U.S. 243, 267 (2006) (discussing interpretation offered "by the Attorney General" as "beyond his expertise and incongruous with the statutory purposes and design"). The Government cannot avoid the major questions doctrine by skirting the regulatory process or enforcement proceedings. *See* 42 U.S.C. §§1395dd(d), 1395hh(a)(2); *cf. Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320,

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[13] *Medicare Monthly Enrollment*, CMS, https://bit.ly/3ONTXxO (last visited Feb. 19, 2024) (Medicare Enrollment) (reporting 383,441 enrollees statewide as of October 2023).

328 (2015) (disfavoring attempts to "circumvent" Congress's prescribed "method of enforcing" statutes). The major questions doctrine, protecting against "unintentional" or "oblique" derogation of powers delegated by Congress, applies no less to the Government's extraordinary pre-enforcement "preemption" suit. *West Virginia*, 142 S. Ct. at 2620 (Gorsuch, J., concurring).

2. There is no clear congressional authorization for the Government's abortion rule.

On the heels of *Dobbs*, the Government suddenly "discover[ed] in a long-extant statute an unheralded power" that results in a "transformative expansion in [its] regulatory authority." *Utility Air*, 573 U.S. at 324. President Biden directed HHS "to protect and expand access to abortion care," including through "updates to current guidance" for EMTALA. 87 Fed. Reg. at 42053-42054. HHS responded with new guidance conceiving of EMTALA as an abortion mandate. *See Texas*, 89 F.4th at 541. Weeks later, the Government deployed that newfound power against Idaho in this unprecedented suit. J.A.3-4. Since then, the White House has linked its reinterpretation of EMTALA with the overruling of *Roe*.[14]

a. Reading EMTALA as an abortion mandate is "unheralded." *Utility Air*, 573 U.S. at 324. As the Fifth

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[14] *See Fact Sheet: White House Task Force on Reproductive Healthcare Access Announces New Actions*, White House (Jan. 22, 2024), https://bit.ly/42NCrPO; *Statement from President Joe Biden on Supreme Court Order on Idaho's Abortion Ban*, White House (Jan. 5, 2024), https://bit.ly/42HQW7X.

Circuit held, that interpretation constitutes "new policy." *Texas*, 89 F.4th at 541. And before *Dobbs*, the courts of appeals all agreed that EMTALA did not require nationwide standards of care, let alone abortion care. *See Summers*, 91 F.3d at 1137.

Few would cavil whether the Government's view of EMTALA results in "an enormous and transformative expansion in … regulatory authority." *Utility Air*, 573 U.S. at 324. EMTALA has long been understood as a patient-dumping statute. *See Marshall*, 134 F.3d at 322. Endorsing the Government's interpretation would effectively transform it into an abortion-access statute.

b. The Government's re-writing of EMTALA is suspect because it relies on "vague terms" never before understood to require abortion. *Whitman*, 531 U.S. at 468. The Government relies largely on the phrase "[n]ecessary stabilizing treatment," appearing in a heading of all places. §1395dd(b); *see Dubin v. United States*, 143 S. Ct. 1557, 1567 (2023) ("A title will not, of course, 'override the plain words of a statute.'"). Like other attempts to concoct administrative power, the phrase "necessary stabilizing treatment" could mean "almost anything" and becomes "an empty vessel" when "shorn of all context." *West Virginia*, 142 S. Ct. at 2614. But the major questions doctrine requires reading EMTALA's terms in context. *See Nebraska*, 143 S. Ct. at 2376 (Barrett, J., concurring). And context reveals that EMTALA's stabilization requirement is meant to ensure hospitals do not refuse to treat patients before transferring or discharging them, not to prescribe specific procedures. Part I.A.1, *supra*.

The Government's rewrite departs from previous agency practice. Before *Dobbs*, HHS invoked EMTALA's stabilization requirement when physicians transferred patients before stabilizing them. *See Cherukuri v. Shalala*, 175 F.3d 446, 448-449 (6th Cir. 1999) (transferring patients with head injuries before performing abdominal surgery); *Burditt v. U.S. Dep't of Health & Hum. Servs.*, 934 F.2d 1362, 1368-1370 (5th Cir. 1991) (transferring a pregnant woman in labor with hypertension). Those decisions did not impose a regulatory straitjacket compelling the same medical treatment for the same medical condition, *contra* §1395. Courts of appeals have rejected the notion that *stabilized* carries "a fixed meaning, which necessarily, and in all events requires" a particular procedure. *Cherukuri*, 175 F.3d at 454; *see Harry v. Marchant*, 291 F.3d 767, 771-773 (11th Cir. 2002). No one could have foreseen the Government's claim that EMTALA requires abortions and preempts state abortion laws.

More troubling, the Government has varied from EMTALA's required procedures for new EMTALA regulations. Medicare requires HHS to promulgate regulations before imposing "a substantive legal standard governing … the eligibility of individuals, entities, or organizations to furnish … services … under this subchapter." 42 U.S.C. §1395hh(a)(2); *see Texas*, 89 F.4th at 545-546. Even then, the Secretary cannot expand EMTALA in such a way that takes control over the practice of medicine. *See Texas*, 89 F.4th at 543.

Finally, the Government's theory advances "a regulatory program that Congress ha[s] conspicuously

and repeatedly declined to enact itself." *West Virginia*, 142 S. Ct. at 2610 (collecting cases). The Government's view of EMTALA would put it on a collision course with federal law expressly addressing abortion in more restrictive ways. Part I.A.2.c, *supra*. Bills proposing a federal right to abortion have failed. *See, e.g.*, Women's Health Protection Act of 2022, H.R. 8296, 117th Cong. §§4(a)(1), 5(a)(1) (proposed legislation prescribing a federal right to "abortion services" that "supersedes" contrary state law); Women's Health Protection Act of 2022, S. 4132, 117th Cong. §§3(a)(1), 4(a)(1) (same). "The importance of the issue," along with the fact that abortion requirements "ha[ve] been the subject of an 'earnest and profound' debate across the country, makes the oblique form of the claimed delegation all the more suspect." *Gonzales*, 546 U.S. at 267 (internal citation omitted).

3. Separation of powers requires reading EMTALA as written.

The major questions doctrine "protect[s] the Constitution's separation of powers" by shielding Congress's lawmaking role from Executive Branch attempts to rewrite Congress's laws. *West Virginia*, 142 S. Ct. at 2617 (Gorsuch, J., concurring). "[W]hen it comes to the Nation's policy, the Constitution gives Congress the reins—a point of context that no reasonable interpreter could ignore" when interpreting the Medicare Act's requirements. *Nebraska*, 143 S. Ct. at 2381 (Barrett, J., concurring).

But here, the Government claims it has the last word on a nationwide abortion rule without Congress's express authority, and it can use this Court to

declare it so. That theory would simply transfer power over national abortion policy from federal courts during the *Roe* era to federal agencies today—still denying "the people of the various States" freedom "to address a question of profound moral and social importance" and "evaluate those interests differently." *Dobbs*, 142 S. Ct. at 2257, 2265. It would allow the Executive Branch to legislate national rules itself, based on "nothing more than the will of the current President, or, worse yet, the will of unelected officials barely responsive to him." *West Virginia*, 142 S. Ct. at 2618 (Gorsuch, J., concurring). Consider that it took HHS only days to respond to the President's call for more "access to abortion," 87 Fed. Reg. at 42053, and only a month to enforce that new policy against Idaho. Left unchecked, "little would remain to stop agencies from moving into areas where state authority has traditionally predominated." *West Virginia*, 142 S. Ct. at 2618 (Gorsuch, J., concurring).

The Framers rejected such concentrations of political power. For them, "[t]he accumulation of all powers legislative, executive and judiciary … may justly be pronounced the very definition of tyranny." The Federalist No. 47, at 324 (Madison) (Jacob E. Cooke ed., 1961). So the Constitution separated those powers and then "deliberately sought to make lawmaking difficult" by vesting all legislative power in Congress, *West Virginia*, 142 S. Ct. at 2618 (Gorsuch, J., concurring), and requiring consensus between the two houses "elected at different times, by different constituencies, and for different terms in office," *Gundy v. United States*, 139 S. Ct. 2116, 2134 (2019) (Gorsuch, J., dissenting).

Article I vests all legislative power in Congress, not the Executive, based on centuries of English and American experience. *See* U.S. Const. art. I, §1; *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92, 116-118 (2015) (Thomas, J., concurring in the judgment); *Dep't of Transp. v. Ass'n of Am. R.R.*, 575 U.S. 43, 70-74 (2015) (Thomas, J., concurring in the judgment). Magna Carta required English monarchs to govern "in accordance with 'the law of the land.'" *Ass'n of Am. R.R.*, 575 U.S. at 72 (Thomas, J., concurring in the judgment); *accord* Magna Carta ch. 39 (1215), *reprinted in* Magna Carta 53 (David Carpenter ed., 2015). Centuries later, Lord Coke rejected King James I's claim to rule "'according to his wisdom,'" *Perez*, 575 U.S. at 124-125 (Thomas, J., concurring), and declared "the King by his Proclamation, or other waies, cannot change any part of the Common Law, or Statute Law, or the Customs of the Realm," *Case of Proclamations* (1610) 77 Eng. Rep. 1352, *reprinted in* 1 The Selected Writings and Speeches of Sir Edward Coke 488 (Steve Sheppard ed., 2003). The Founders knew that history well and demanded "that the power to make the standing rules and the power to enforce them not lie in the same hands." *Ass'n of Am. R.R.*, 575 U.S. at 73 (Thomas, J., concurring); *see* Novanglus, Letter, *To the Inhabitants of the Colony of Massachusetts-Bay*, Bos. Gazette, Jan. 23, 1775 (observing that "the people of England, and the cause of liberty, truth, virtue and humanity gained infinite advantages by that resistance" to the lawless measures of English kings), *reprinted in* J. Adams, Revolutionary Writings 1755-1775 390-391 (Gordon Wood ed., 2011). That history lies behind the Constitution's separation of powers,

requiring that "Congress makes laws and the President, acting at times through agencies like EPA [or DOJ and HHS], 'faithfully execute[s]' them." *Utility Air*, 573 U.S. at 327 (quoting U.S. Const. art. II, §3).

"The Founders of this Nation entrusted the law making power to the Congress alone in both good and bad times," before *Roe*, during, and after. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 589 (1952). Congress has legislated on abortion but did not do so in EMTALA, and "no just rule of construction would tolerate a grant of such power by mere implication." *Cincinnati, N.O. & T.P. R.*, 167 U.S. at 494-495. The Executive Branch's attempt to take the drafting pen from Congress ignores its "duty" to show "fidelity to the law itself, not to every presidential policy preference." *Seila Law LLC v. CFPB*, 140 S. Ct. 2183, 2228 (2020) (Kagan, J., concurring in part and dissenting in part). That principle limits federal power. For "our system does not permit agencies to act unlawfully even in pursuit of desirable ends." *Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2490 (2021) (per curiam).

B. Construing EMTALA to preempt Idaho's abortion law would exceed Congress's spending power.

The Government says EMTALA "reflects Congress's 'broad power under the Spending Clause' to 'set the terms on which it disburses federal funds.'" U.S. Stay Resp. 36-37 (quoting *Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562, 1568 (2022)).

But Idaho never accepted those terms. The Government has no apparent "power" to use such spending terms to preempt state law. *Murphy*, 584 U.S. at 477.

1. If the Government's preemption theory were right, then the spending power would be an instrument of unlimited federal power. The Government could simply pay hospitals to violate state law. Imagine, for example, federal spending conditioned on allowing assisted suicide. In the Government's view, Congress could tell hospitals, "Once you accept federal funds, you must provide assisted suicide," irrespective of state law and even though beyond Congress's enumerated powers. *Cf. Washington v. Glucksberg*, 521 U.S. 702, 732-736 (1997). If the Spending Clause, combined with the Supremacy Clause, could give such priority "to every federal policy about anything" attached to spending legislation, then there is no limiting federal power. D. Engdahl, *The Spending Power*, 44 Duke L.J. 2, 42, 77-78 (1994).

Any such preemption power would exceed Congress's power to *influence* policy by spending. *See South Dakota v. Dole*, 483 U.S. 203, 207 (1987). It would allow Congress to *coerce* policy by spending, no different than when Congress enacts federal bankruptcy or immigration laws pursuant to its enumerated powers. *But see NFIB v. Sebelius*, 567 U.S. 519, 579 (2012); *New York v. United States*, 505 U.S. 144, 176 (1992).

Congress's spending power is not so unbounded. Spending legislation is not "ordinary legislation" but instead "operates based on consent." *Cummings*, 142 S. Ct. at 1570. It "is much in the nature of a contract:

in return for federal funds, the States agree to comply with federally imposed conditions." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Conditions must be accepted "voluntarily and knowingly," and Congress must attach such conditions "unambiguously." *Id.* They are not mandatory, meaning Congress cannot "force[] a … law upon" the State with such conditions. *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 595 (1937); *see Townsend v. Swank*, 404 U.S. 282, 292 (1971) (Burger, C.J., concurring in the judgment). States retain the right "to defend their prerogatives by adopting 'the simple expedient of not yielding' to federal blandishments when they do not want to embrace the federal policies as their own." *NFIB*, 567 U.S. at 579 (quoting *Massachusetts v. Mellon*, 262 U.S. 447, 482 (1923)).

Accordingly, Congress cannot use its spending power to command Idaho or any other State to set aside its laws without the State's voluntary and knowing acceptance. *See Pennhurst*, 451 U.S. at 17, 25; *NFIB*, 567 U.S. at 576. Idaho has never so consented. The Government's Medicare agreements are with hospitals, not Idaho. *See* J.A.7-8. Indeed, the only state hospital participating in Medicare is a psychiatric hospital with no emergency department. J.A.531-532. By presenting its preemption theory as a *fait accompli*, the Government forgets that EMTALA, as a spending condition, has no force unless accepted. *See Mellon*, 262 U.S. at 482; *see* P. Hamburger, Purchasing Submission: Conditions, Power, and Freedom 129-133 (2021) (distinguishing spending conditions on those grounds for Supremacy Clause purposes). The

Government cannot force its view of EMTALA upon the State and declare Idaho law preempted. *See Steward Mach.*, 301 U.S. at 595.

This suit is thus unlike those brought to enforce spending conditions against recipients of federal funding programs. *See, e.g.*, *Maine v. Thiboutot*, 448 U.S. 1, 2-3 (1980); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 681-682 (1979). It isn't even about the funds themselves. *See, e.g.*, *Philpott v. Essex Cnty. Welfare Bd.*, 409 U.S. 413, 417 (1973); *Townsend*, 404 U.S. at 283-285. Instead, by suing Idaho, the Government asks to transform a spending condition for hospitals into a line-item veto for state law about the practice of medicine. *But see, e.g.*, *Linder v. United States*, 268 U.S. 5, 18-23 (1925); A. Hamilton, *Report on the Subject of Manufactures* 54-55 (1791) (Brown ed., 1827) (observing spending power did not "imply a power to do whatever else should appear to Congress conducive to the general welfare").

2. Nor could States knowingly or voluntarily consent to the Government's version of EMTALA, preempting state abortion laws. Congress did not speak "with a clear voice" to require abortion access as a "consequence[] of … participation" in Medicare. *Pennhurst*, 451 U.S. at 17. The Government cannot now "force unwilling States" to acquiesce to that newfound requirement by "threat" of losing substantial federal funding. *NFIB*, 567 U.S. at 580.

But here, the threat is plain. The Government alleges Idaho law "undermines the overall Medicare program" and denies the Government "the benefit of

its bargain." J.A.18. Put simply, unless Idaho hospitals perform abortions when HHS says so, they stand to lose substantial Medicare funding. The Secretary announced that a hospital risks "termination of its Medicare provider agreement." *See* Becerra Letter, *supra* n.11.

The financial and public-health stakes of the Government's threat are alarming. Medicare spending approached $1 trillion in 2022, exceeding federal Medicaid spending. NHE Fact Sheet, *supra* n.12. Between 2018 and 2020, Idaho hospitals received $74 million for emergency departments and $3.4 billion in overall Medicare funding. J.A.385. Roughly 380,000 Idaho residents are Medicare enrollees who depend on Idaho's Medicare-participating hospitals for medical care. *See* Medicare Enrollment, *supra* n.13. No one should doubt that the Government's threat is ultimately directed at the State. Terminating Medicare funding and excluding hospitals from Medicare would create a financial and public-health crisis in Idaho, and Idaho would be left holding the bag.

The Government's abortion condition is an impermissible "gun to the head." *NFIB*, 567 U.S. at 581. It is not even about "the use of the funds." *Id.* at 580. Nor does it reflect Congress's view of the "general Welfare." *Id.* For decades, Congress has not funded abortions that the Government now says are required. Part I.A.2.c, *supra*. The Government has no power to "pressur[e] the States to accept policy changes" that not even Congress accepts. *NFIB*, 567 U.S. at 580.

Congress's power to spend encompasses the power to take away—sometimes. *Id.*; *see Oklahoma v. U.S. Civil Serv. Comm'n*, 330 U.S. 127, 143-144 (1947). But

there is no enumerated power to place "state legislatures … under the direct control of Congress." *Murphy*, 584 U.S. at 474. Congress can "encourage the States" but not "compel." *New York*, 505 U.S. at 149. The Government cannot circumvent those federalism principles with a novel preemption theory that exceeds well-established limits of the federal spending power.

C. Construing EMTALA to require abortion invades Idaho's sovereignty contrary to the Tenth Amendment.

The Government's novel preemption theory exceeds congressional authorization and constitutional limitations. Without authority to preempt state law, the Government encroaches on Idaho's sovereign authority over abortion. Congress has given every indication that it intended to respect the States' primary authority over healthcare—not displace it. Given clear statutory provisions *not* to displace state law, the Government cannot overcome clear-statement rules designed to preserve the Constitution's "dual system of sovereignty between the States and the Federal Government." *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991).

Federal powers "are few and defined," while those that "remain in the State Governments are numerous and indefinite." The Federalist No. 45, at 313 (Madison) (Jacob E. Cooke ed., 1961). "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X. Dividing power "enhances freedom, first by

protecting the integrity of the governments themselves, and second by protecting the people, from whom all governmental powers are derived." *Bond v. United States*, 564 U.S. 211, 221 (2011). And it leaves to the States the "broad authority to enact legislation for the public good." *Bond v. United States*, 572 U.S. 844, 854 (2014). Idaho retains that authority here.

From the beginning, this Court explained that "[t]o interfere with the penal laws of a State … is a very serious measure, which Congress cannot be supposed to adopt lightly, or inconsiderately. … It would be taken deliberately, and the intention would be clearly and unequivocally expressed." *Cohens v. Virginia*, 19 U.S. (6 Wheat.) 264, 443 (1821); A. Barrett, *Substantive Canons and Faithful Agency*, 90 B.U. L. Rev. 109, 153-154 (2010) (collecting additional cases). Accordingly, the Court requires "exceedingly clear language if [Congress] wishes to significantly alter the balance between federal and state power." *Sackett v. EPA*, 143 S. Ct. 1322, 1341 (2023). And the related presumption against preemption assumes that "the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rice*, 331 U.S. at 230; *see, e.g.*, *Reid v. Colorado*, 187 U.S. 137, 147-150 (1902). Both rules prevent the casual takeover of the States' authority to regulate matters "at the core of traditional state authority." *Sackett*, 143 S. Ct. at 1341.

Requiring "exceedingly clear language," *id.*, or a "clear and manifest [congressional] purpose," *Medtronic*, 518 U.S. at 485, to displace state abortion regulations is especially appropriate. Abortion has long been subject to differing schemes of state regulation.

See Dobbs, 142 S. Ct. at 2251-2253 (tracing history of state abortion regulation); *see also Memphis Ctr. for Reprod. Health v. Slatery*, 14 F.4th 409, 448-449 (6th Cir. 2021) (Thapar, J., concurring in part and dissenting in part) (noting States enacted 90 abortion-related laws in the first half of 2021). When Congress adds its voice to those state laws, it does so overtly and unambiguously, not silently or indirectly, and it often does so with deference toward state law and the conscience rights of healthcare providers. *See, e.g.*, 18 U.S.C. §§248(d)(4), 1531(a); 42 U.S.C. §§289g-1(b)(2)(A), 300a-7(c), 300a-8, 1396u-2(e)(1)(B), 18023(a)(1).

But here, the Government ignores those clear-statement rules and contends Congress silently displaced state abortion laws. EMTALA contains no "exceedingly clear language" to override such laws, *Sackett*, 143 S. Ct. at 1341, even though they are in the heartland of the States' police powers, *see Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954). Quite the opposite: EMTALA does "not" preempt state law unless "directly" conflicting. §1395dd(f). Locating an abortion requirement in that text would be the most "obscure grant of authority to regulate areas traditionally supervised by the States' police power." *Gonzales*, 546 U.S. at 274. Turning a blind eye to EMTALA's limited reach, as the Government does, deprives the people of Idaho of their right of self-government concerning abortion.

The Government has no power to exceed those constitutional limits with this unprecedented lawsuit. Idaho waited nearly 50 years to reclaim the sovereign

authority to legislate on abortion. The State did so after *Dobbs* "return[ed] the issue of abortion to the people's elected representatives." 142 S. Ct. at 2243. Within weeks, the Government hauled Idaho into federal court and demanded its compliance with a newfound abortion mandate for which EMTALA is a pretext. The Government has no power to place state legislatures under its control. *See Murphy*, 584 U.S. at 474; *New York*, 505 U.S. at 176. Its novel preemption theory denies States and the American people the freedom to chart their own course. If the Government's view of preemption were correct, then the guarantee of "dual sovereignty" would be gone. *Gregory*, 501 U.S. at 457.

CONCLUSION

There is no basis for a preliminary injunction against Idaho's Defense of Life Act. The Ninth Circuit's order should be reversed and the preliminary injunction vacated.

Respectfully submitted,

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February 20, 2024

STATUTORY APPENDIX

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42 U.S.C. §1395dd

(current)

§1395dd. Examination and treatment for emergency medical conditions and women in labor.

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(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 either—

(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, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the

individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer

to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician

fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in

which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of

a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means—

(A) 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; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), 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, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely,

within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

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.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma

units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

42 U.S.C. §1395

(current)

§1395. Prohibition against any Federal interference.

Nothing 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, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 U.S.C. §1395dd

(1988)

§1395dd. Examination and treatment for emergency medical conditions and women in active labor.

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2) of this section).

(b) Necessary stabilizing treatment for emergency medical conditions and active 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 or is in active labor, the hospital must provide either—

(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 or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an-individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section) or is in active labor, the hospital may not transfer the patient unless—

(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

(ii) a physician (within the meaning of section 1395x(r)(1) of this title), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the patient, and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(d) Enforcement

(1) As requirement of medicare provider agreement

If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

(2) Civil money penalties

(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) The responsible physician in a participating hospital with respect to the hospital's

violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.

(C) As used in this paragraph, the term "responsible physician" means, with respect to a hospital's violation of a requirement of this section, a physician who—

(i) is employed by, or under contract with, the participating hospital, and

(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

(3) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means 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—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which—

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(4)(A) The term "to stabilize" means, with respect to an emergency medical condition, 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 the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) Preemption

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.

Exec. Order No. 14076, 87 FR 42053

Protecting Access to Reproductive Healthcare Services

(July 8, 2022)

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Policy.

Nearly 50 years ago, *Roe v. Wade*, 410 U.S. 113 (1973), articulated the United States Constitution's protection of women's fundamental right to make reproductive healthcare decisions. These deeply private decisions should not be subject to government interference. Yet today, fundamental rights—to privacy, autonomy, freedom, and equality—have been denied to millions of women across the country.

Eliminating the right recognized in *Roe* has already had and will continue to have devastating implications for women's health and public health more broadly. Access to reproductive healthcare services is now threatened for millions of Americans, and especially for those who live in States that are banning or severely restricting abortion care. Women's health clinics are being forced to close—including clinics that offer other preventive healthcare services such as contraception—leaving many communities without access to critical reproductive healthcare services. Women seeking abortion care—especially those in

low-income, rural, and other underserved communities—now have to travel to jurisdictions where services remain legal notwithstanding the cost or risks.

In the face of this health crisis, the Federal Government is taking action to protect healthcare service delivery and promote access to critical reproductive healthcare services, including abortion. It remains the policy of my Administration to support women's right to choose and to protect and defend reproductive rights. Doing so is essential to justice, equality, and our health, safety, and progress as a Nation.

Sec. 2. Definitions.

(a) The term "agency" means any authority of the United States that is an "agency" under 44 U.S.C. 3502(1), other than one considered to be an independent regulatory agency, as defined in 44 U.S.C. 3502(5).

(b) The term "reproductive healthcare services" means medical, surgical, counseling, or referral services relating to the human reproductive system, including services relating to pregnancy or the termination of a pregnancy.

Sec. 3. Protecting Access to Reproductive Healthcare Services.

(a) Within 30 days of the date of this order, the Secretary of Health and Human Services shall submit a report to the President:

(i) identifying potential actions:

(A) to protect and expand access to abortion care, including medication abortion; and

(B) to otherwise protect and expand access to the full range of reproductive healthcare services, including actions to enhance family planning services such as access to emergency contraception;

(ii) identifying ways to increase outreach and education about access to reproductive healthcare services, including by launching a public awareness initiative to provide timely and accurate information about such access, which shall:

(A) share information about how to obtain free or reduced cost reproductive healthcare services through Health Resources and Services Administration-Funded Health Centers, Title X clinics, and other providers; and

(B) include promoting awareness of and access to the full range of contraceptive services, as well as know-your-rights information for those seeking or providing reproductive healthcare services; and

(iii) identifying steps to ensure that all patients—including pregnant women and those experiencing pregnancy loss, such as

miscarriages and ectopic pregnancies—receive the full protections for emergency medical care afforded under the law, including by considering updates to current guidance on obligations specific to emergency conditions and stabilizing care under the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd, and providing data from the Department of Health and Human Services concerning implementation of these efforts.

(b) To promote access to reproductive healthcare services, the Attorney General and the Counsel to the President shall convene a meeting of private pro bono attorneys, bar associations, and public interest organizations in order to encourage lawyers to represent and assist patients, providers, and third parties lawfully seeking these services throughout the country.

Sec. 4. Protecting Privacy, Safety, and Security.

(a) To address potential heightened safety and security risks related to the provision of reproductive healthcare services, the Attorney General and the Secretary of Homeland Security shall consider actions, as appropriate and consistent with applicable law, to ensure the safety of patients, providers, and third parties, and to protect the security of clinics (including mobile clinics), pharmacies, and other entities providing, dispensing, or delivering reproductive and related healthcare services.

(b) To address the potential threat to patient privacy caused by the transfer and sale of sensitive health-related data and by digital surveillance related to reproductive healthcare services, and to protect people seeking reproductive health services from fraudulent schemes or deceptive practices:

(i) The Chair of the Federal Trade Commission (FTC) is encouraged to consider actions, as appropriate and consistent with applicable law (including the Federal Trade Commission Act, 15 U.S.C. 41 et seq.), to protect consumers' privacy when seeking information about and provision of reproductive healthcare services.

(ii) The Secretary of Health and Human Services shall consider actions, including providing guidance under the Health Insurance Portability and Accountability Act, Public Law 104-191, 110 Stat. 1936 (1996) as amended by Public Law 111-5, 123 Stat. 115 (2009), and any other statutes as appropriate, to strengthen the protection of sensitive information related to reproductive healthcare services and bolster patient-provider confidentiality.

(iii) The Secretary of Health and Human Services shall, in consultation with the Attorney General, consider actions to educate consumers on how best to protect their health privacy and limit the collection and

sharing of their sensitive health-related information.

(iv) The Secretary of Health and Human Services shall, in consultation with the Attorney General and the Chair of the FTC, consider options to address deceptive or fraudulent practices related to reproductive healthcare services, including online, and to protect access to accurate information.

Sec. 5. Coordinating Implementation Efforts.

(a) The Secretary of Health and Human Services and the Director of the Gender Policy Council shall establish and co-chair an Interagency Task Force on Reproductive Healthcare Access (Task Force). Additional members shall include the Attorney General and the heads of other agencies as determined by the Secretary of Health and Human Services and the Director of the Gender Policy Council. The Task Force shall work to identify and coordinate activities to protect and strengthen access to essential reproductive healthcare services. In addition, the Task Force shall coordinate Federal interagency policymaking, program development, and outreach efforts to address barriers that individuals and entities may face in seeking and providing reproductive healthcare services. The Department of Health and Human Services

shall provide funding and administrative support as may be necessary for the performance and functions of the Task Force.

(b) The Attorney General shall provide technical assistance, as appropriate and consistent with applicable law, concerning Federal constitutional protections to States seeking to afford legal protection to out-of-State patients and providers who offer legal reproductive healthcare.

Sec. 6. General Provisions.

(a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss

(QSO-21-22-Hospitals-UPDATED JULY 2022)

DATE: July 11, 2022

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals-UPDATED JULY 2022)

Memorandum Summary

- The Emergency Medical Treatment and Labor Act (EMTALA) provides rights to any individual who comes to a hospital emergency department and requests examination or treatment. In particular, if such a request is made, hospitals must provide an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the person is in labor. If an emergency medical condition is found to exist, the hospital must provide available stabilizing treatment or an appropriate transfer to another hospital that

has the capabilities to provide stabilizing treatment. The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary, **irrespective of any state laws or mandates that apply to specific procedures.**

- The determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.

- Hospitals should ensure all staff who may come into contact with a patient seeking examination or treatment of a medical condition are aware of the hospital's obligation under EMTALA.

- A physician's professional and legal duty to provide stabilizing medical treatment to a patient who presents under EMTALA to the emergency department and is found to have an emergency medical condition **preempts any directly conflicting state law or mandate** that might otherwise prohibit or prevent such treatment.

- If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician **must** provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—**that state law is preempted**.

  NOTE: This memorandum is being issued to remind hospitals of their existing obligation to comply with EMTALA and does not contain new policy.

Background

The purpose of this memorandum is to restate existing guidance for hospital staff and physicians regarding their obligations under the Emergency Medical Treatment and Labor Act (EMTALA), in light of new state laws prohibiting or restricting access to abortion.

The EMTALA statute is codified at section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. Hospitals and physicians generally have three obligations under EMTALA.[1] The first is commonly referred to as the *screening requirement*, and applies to any individual

[1] Appendix V of the CMS State Operations Manual-: https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf.

who comes to the emergency department for whom a request is made for examination or treatment of a medical condition, including people in labor or those with an emergency condition such as an ectopic pregnancy. Such an individual is entitled to have a medical screening examination to determine whether an emergency medical condition (EMC) exists. The second obligation is commonly referred to as the *stabilization requirement*, which applies to any individual who comes to the hospital whom the hospital determines has an emergency medical condition. Such an individual is entitled to stabilizing treatment within the capability of the hospital. The third obligation flows from the second, and also applies to any individual in a hospital with an emergency medical condition. This obligation is sometimes known as the *transfer requirement*, which restricts the ability of the hospital to transfer that individual to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (e.g., the hospital does not have the capability to stabilize the condition).

While a patient may request a transfer for any reason, a hospital is restricted by EMTALA to transfer patients only after a physician certifies that the medical benefits of the transfer outweigh the risks. The EMTALA regulation at 42 CFR §489.24 clarifies that the screening requirement applies to any individual who presents to an area of the hospital that meets the definition of a "dedicated emergency department" and makes a request for a medical screening examination.

The regulation defines dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it holds itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. Based on this definition, it is likely that the labor and delivery unit of a hospital could meet the definition of dedicated emergency department.

Medicare Conditions of Participation

Hospitals are also bound by the Medicare conditions of participation (CoPs) to provide appropriate care to inpatients (42 C.F.R. 482.1 through 482.58). In particular, four CoPs are potentially applicable when a hospital provides treatment for an admitted patient. For example, the governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients (42 C.F.R. 482.12(a)(5) and 42 C.F.R. 482.22). Further, the discharge planning CoP (42 C.F.R. 482.43), which requires that hospitals have a discharge planning process, applies to all patients. Finally, the hospital governing body must ensure that the hospital has an organization-wide quality assessment and performance improvement program to evaluate the provision of patient care (42 C.F. R. 482.21). These CoPs are intended to protect patient health and safety, and to ensure that high quality medical care is provided to all patients. Failure to meet these CoPs could result in a finding of noncompliance at the condition level for

the hospital and lead to termination of the hospital's Medicare provider agreement.

EMTALA

There are several specific provisions we wish to call attention to under EMTALA:

Emergency Medical Condition (EMC):

Once an individual has presented to the hospital seeking emergency care, the determination of whether an Emergency Medical Condition exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

An EMC includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious impairment or dysfunction of bodily functions or any bodily organ. Further, an emergency medical condition exists if the patient may not have enough time for a safe transfer to another facility, or if the transfer might pose a threat to the safety of the person.

Labor

"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A person experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other qualified medical person acting within their scope of practice as defined in hospital

medical staff bylaws and State law, certifies that, after a reasonable time of observation, the person is in false labor.

Medical Screening Examination

Individuals coming to the "emergency department" must be provided a medical screening examination appropriate to the presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if they do, until they are stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

People in Labor

- Regardless of State laws, requirements, or other practice guidelines, EMTALA requires that a person in labor may be transferred only if the individual or their representative requests the transfer after informed consent or if a physician or other

qualified medical personnel signs a certification at the time of transfer, with respect to the person in labor, that "the benefits of the transfer to the woman and/or the unborn child outweigh its risks."[2] For example, if the hospital does not have staff or resources to provide obstetrical services, the benefits of a transfer may outweigh the risks.

- **A hospital cannot cite State law or practice as the basis for transfer.** Fear of violating state law through the transfer of the patient cannot prevent the physician from effectuating the transfer nor can the physician be shielded from liability for erroneously complying with state laws that prohibit services such as abortion or transfer of a patient for an abortion when the original hospital does not have the capacity to provide such services. When a direct conflict occurs between EMTALA and a state law, EMTALA must be followed.

- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the

[2] State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, 52, https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf.

screening, treatment, and transfer requirements.

Stabilizing Treatment

After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity. Section 42 CFR 489.24(b) defines **stabilized** to mean:

> "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition…."

The EMTALA statute requires that stabilizing treatment prevent material deterioration and compels hospitals and physicians to act prior to the patient's condition declining. The course of stabilizing treatment is under the purview of the physician or qualified medical personnel. If qualified medical personnel determine that the patient's condition, such as an ectopic pregnancy, requires stabilizing treatment to prevent serious jeopardy to the patient's health (including a serious impairment or dysfunction of bodily functions or any bodily organ or a threat to life), the qualified medical personnel is required by EMTALA to provide the treatment.

As indicated above, the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., methotrexate therapy, dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.).

Hospital's Obligation

A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);

- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or

- That an emergency medical condition exists and the individual is stabilized or admitted to the hospital for further stabilizing treatment.

Any state that has a more restrictive definition of emergency medical condition or that has a definition that directly conflicts with any definition above is preempted by the EMTALA statute. Physicians and hospitals have an obligation to follow the EMTALA definitions, even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located. Hospitals and physicians have an affirmative obligation to provide all necessary stabilizing treatment options to an individual with an emergency medical condition.

The EMTALA statute requires that all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures.

A physician's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment. EMTALA's preemption of state law could be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute's retaliation provision.

Enforcement

HHS, through its Office of the Inspector General (OIG), may impose a civil monetary penalty on a hospital ($119,942 for hospitals with over 100 beds, $59,973 for hospitals under 100 beds/per violation) or physician ($119,942/violation) pursuant to 42 CFR §1003.500 for refusing to provide either any necessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. Under this same authority, HHS OIG may also exclude physicians from participation in Medicare and State health care programs. CMS may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping any equitable relief as is appropriate. 42 U.S.C. § 1395dd(d)(2)(A).

Any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital would be preempted by the federal EMTALA statute due to the direct conflict with the "stabilized" provision of the statute. Moreover, EMTALA contains a whistleblower provision that prevents retaliation by the hospital against any hospital employee or physi-

cian who refuses to transfer a patient with an emergency medical condition that has not been stabilized by the initial hospital, such as a patient with an emergent ectopic pregnancy, or a patient with an incomplete medical abortion.

To file an EMTALA complaint, please contact the appropriate state survey agency: https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/SurveyCertificationGenInfo/ContactInformation

Individuals who believe they have been discriminated against on the basis of race, color, national origin, sex (including sexual orientation, gender identity, and pregnancy), age, disability, religion, or the exercise of conscience in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, may file a complaint with the HHS Office for Civil Rights at http://www.hhs.gov/civil-rights/filing-a-complaint/complaintprocess/index.html.[3] With regard to civil rights protections against national origin discrimination, hospitals covered by EMTALA must take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency (LEP). In most cases, hospitals must provide some form of language assistance service, such as provide an interpreter at no cost to the patient or provide important documents translated into the patient's preferred language. Hospitals

[3] For more information about the laws and regulations enforced by OCR, please visit https://www.hhs.gov/civilrights/for-providers/laws-regulations-guidance/laws/index.html.

may learn more about their obligations to persons with LEP by visiting the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.*

Contact: Questions about this memorandum should be addressed to QSOG_Hospital@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

Karen L. Tritz, Director, Survey & Operations Group,
David R. Wright Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

Idaho Code §18-604. Definitions.

(current)

As used in this chapter:

(1) "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean:

(a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus;

(b) The removal of a dead unborn child;

(c) The removal of an ectopic or molar pregnancy; or

(d) The treatment of a woman who is no longer pregnant.

(2) "Department" means the Idaho department of health and welfare.

(3) "Down syndrome" means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for

chromosome 21. Down syndrome is sometimes referred to as "trisomy 21."

(4) "Emancipated" means any minor who has been married or is in active military service.

(5) "Fetus" and "unborn child." Each term means an individual organism of the species Homo sapiens from fertilization until live birth.

(6) "First trimester of pregnancy" means the first thirteen (13) weeks of a pregnancy.

(7) "Hospital" means an acute care general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(8) "Informed consent" means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption.

The physician must provide the information in terms that can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.

(9) "Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(10) "Minor" means a woman under eighteen (18) years of age.

(11) "Pregnant" and "pregnancy." Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(12) "Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(13) "Second trimester of pregnancy" means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18-608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(14) "Third trimester of pregnancy" means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

(15) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

Idaho Code §18-622. Defense of Life Act.

(current)

(1) Except as provided in subsection (2) of this section, every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

(2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section:

(a) The abortion was performed or attempted by a physician as defined in this chapter and:

(i) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the

pregnant woman because the physician believes that the woman may or will take action to harm herself; and

(ii) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b) The abortion was performed or attempted by a physician as defined in this chapter during the first trimester of pregnancy and:

(i) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported to a law enforcement agency that she is the victim of an act of rape or incest and provided a copy of such report to the physician who is to perform the abortion. The copy of the report shall remain a confidential part of the woman's medical

record subject to applicable privacy laws; or

(ii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported to a law enforcement agency or child protective services that she is the victim of an act of rape or incest and a copy of such report has been provided to the physician who is to perform the abortion. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws.

(3) If a report concerning an act of rape or incest is made to a law enforcement agency or child protective services pursuant to subsection (2)(b) of this section, then the person who made the report shall, upon request, be entitled to receive a copy of such report within seventy-two (72) hours of the report being made, provided that the report may be redacted as necessary to avoid interference with an investigation.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

2023 Idaho Laws Ch. 298 (H.B. 374)

AN ACT RELATING TO ABORTION; AMENDING SECTION 18-604, IDAHO CODE, TO REVISE A DEFINITION AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 18-622, IDAHO CODE, TO REVISE THE SECTION CAPTION, TO REMOVE OBSOLETE LANGUAGE, TO PROVIDE THAT CERTAIN ABORTIONS AND ATTEMPTS ARE NOT CRIMINAL ABORTIONS, TO PROVIDE THAT CERTAIN PERSONS SHALL BE ENTITLED TO RECEIVE A CERTAIN REPORT UPON REQUEST AND TO MAKE A TECHNICAL CORRECTION; PROVIDING APPLICABILITY; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 18-604, Idaho Code, be, and the same is hereby amended to read as follows:

§ 18–604. Definitions

As used in this ~~act~~ **chapter**:

(1) "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean ~~the~~**:**

(a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization**,** or the implantation of a fertilized ovum within the uterus**;**

(b) The removal of a dead unborn child;

(c) The removal of an ectopic or molar pregnancy; or

(d) The treatment of a woman who is no longer pregnant.

(2) "Department" means the Idaho department of health and welfare.

(3) "Down syndrome" means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as "trisomy 21."

(4) "Emancipated" means any minor who has been married or is in active military service.

(5) "Fetus" and "unborn child." Each term means an individual organism of the species Homo sapiens from fertilization until live birth.

(6) "First trimester of pregnancy" means the first thirteen (13) weeks of a pregnancy.

(7) "Hospital" means an acute care general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(8) "Informed consent" means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption. The physician must provide the information in terms that can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.

(9) "Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of

a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(10) "Minor" means a woman under eighteen (18) years of age.

(11) "Pregnant" and "pregnancy." Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(12) "Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(13) "Second trimester of pregnancy" means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18–608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(14) "Third trimester of pregnancy" means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

(15) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

SECTION 2. That Section 18-622, Idaho Code, be, and the same is hereby amended to read as follows:

§ 18-622. ~~Criminal abortion~~ Defense of life act

~~(1) Notwithstanding any other provision of law, this section shall become effective thirty (30) days following the occurrence of either of the following circumstances:~~

~~(a) The issuance of the judgment in any decision of the United States supreme court that restores to the states their authority to prohibit abortion; or~~

~~(b) Adoption of an amendment to the United States constitution that restores to the states their authority to prohibit abortion.~~

~~(2) Every~~ **(1) Except as provided in subsection (2) of this section, every** person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than **five** (5)

years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

~~(3) It shall be an affirmative defense to prosecution under subsection (2) of this section and to any disciplinary action by an applicable licensing authority, which must be proven by a preponderance of the evidence, that:~~

(2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section:

(a) ~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ **and:**

~~(ii)~~ **(i)** The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and

~~(iii)~~ **(ii)** The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b) ~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ **during the first trimester of pregnancy and:**

~~(ii)~~ **(i)** If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported ~~the act of rape or incest~~ to a law enforcement agency **that she is the victim of an act of rape or incest** and provided a copy of such report to the physician who is to perform the abortion~~;~~**. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws; or**

~~(iii)~~ **(ii)** If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported ~~the act of rape or incest~~ to a law enforcement agency or child protective services **that she is the victim of an act of rape or incest** and a copy of such report has been provided to the physician who is to perform the abortion~~; and~~**. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws.**

~~(iv) The physician who performed the abortion complied with the requirements of paragraph (a)(iii) of this subsection regarding the method of abortion.~~

(3) If a report concerning an act of rape or incest is made to a law enforcement agency or child protective services pursuant to subsection (2)(b) of this section, then the person who made the report shall, upon request, be entitled to receive a copy of such report within seventy-two (72) hours of the report being made, provided that the report may be redacted as necessary to avoid interference with an investigation.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined

in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

SECTION 3. Section 2 of this act shall apply retroactively to any pending claim or defense, whether or not asserted, as of July 1, 2023.

SECTION 4. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after July 1, 2023.

Approved April 4, 2023.
Effective: July 1, 2023.