Nos. 23-726 and 23-727

In the Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,
Petitioners,
v.
UNITED STATES,
Respondent.

IDAHO,
Petitioner,
v.
UNITED STATES,
Respondent.

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

BRIEF OF *AMICI CURIAE* PREGNANCY JUSTICE, NEW YORK UNIVERSITY SCHOOL OF LAW REPRODUCTIVE JUSTICE CLINIC AND IF/WHEN/HOW IN SUPPORT OF RESPONDENT

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Pregnancy Justice, NYU School of Law Reproductive Justice Clinic, and If/When/How (collectively, "*Amici*") respectfully submit this brief in support of the Respondent, the United States.[1]

Pregnancy Justice is a legal advocacy non-profit organization fighting for the civil and human rights of pregnant people. As one of the preeminent legal advocacy organizations focused on the criminal defense of women and pregnant people charged with pregnancy-related crimes, Pregnancy Justice and its clients are uniquely impacted by decisions that embed concepts of fetal personhood into law, which place pregnant people at unique risk of rights violations, criminal charges, and family surveillance and separation.

The Reproductive Justice Clinic at NYU School of Law is a law school clinic focused on defending and advancing the rights and health of all women and pregnant people and their families. Guarantees of dignity, equality, autonomy, and body sovereignty are essential to realizing these rights.

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[1] Pursuant to Rule 37.6 of this Court, *Amici* affirm that no counsel for a party authored this brief in whole or in part, and that no party, counsel for a party, or any person other than *Amici*, their members, or their counsel made a monetary contribution to fund preparation or submission of the brief.

If/When/How: Lawyering for Reproductive Justice is a national non-profit organization working to transform law and policy so that everyone has the power to determine if, when, and how to define, create, and sustain families with dignity. If/When/How provides legal services, conducts strategic advocacy and public education, and organizes the legal profession to ensure that every person has the rights and resources to make reproductive decisions free from discrimination, coercion, or violence.

Amici respectfully request that this Court hold that Idaho's Defense of Life Act, Idaho Code § 18-622, is preempted to the extent it conflicts with the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA").

SUMMARY OF ARGUMENT

This case asks whether Idaho can use its criminal abortion ban to deny pregnant women their federal statutory rights under EMTALA, and, correspondingly, their autonomy, health, and safety. Passed nearly 40 years ago, EMTALA grants anyone facing a medical emergency the right to receive stabilizing healthcare at Medicare-funded emergency rooms. For pregnant women, this care may include abortion, which can be the only treatment to save a pregnant woman's health or life. Idaho now seeks to upend the longstanding *status quo* of emergency abortion care under EMTALA based on a radical claim: that its *State* abortion ban supplants pregnant

women's *federal* EMTALA rights.[2] Idaho Code § 18-622 (the "Total Ban").

The reality is that the Total Ban irreconcilably conflicts with EMTALA and is preempted. EMTALA protects pregnant women's lives and health by granting them a federal right to emergency stabilizing abortion care. Under EMTALA, hospitals must offer abortion care to a pregnant woman where needed to avoid "material deterioration" of her health. Idaho demands the very opposite: if a pregnant woman's emergency requires an abortion, her health *must* materially deteriorate to the point where the abortion is deemed "necessary" to save her life. If a pregnant woman is injured, maimed, or permanently disabled by the delay in needed abortion care, so be it—Idaho asserts she has no say in the matter. It is impossible for healthcare providers to comply with both of these laws.

Faced with this clear conflict, Idaho claims that EMTALA says something it does not. Idaho latches onto EMTALA's references to "unborn child"—in definitional sections and provisions related to safe transfer—and claims that Congress must have guaranteed an EMTALA right to *two* patients *equally*:

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[2] For ease of reference (and because they make overlapping arguments), *Amici* use "Idaho" to refer collectively to Petitioner State of Idaho and to Petitioner Mike Moyle, Speaker of the Idaho House of Representatives; Chuck Winder, President Pro Tempore of the Idaho Senate, and the Sixty-Seventh Idaho Legislature. *Amici* refer to the former Petitioner's brief as "Idaho Br." and to the latter Petitioner's brief as "Legislature Br."

the pregnant woman and the fetus she carries. What is more, in Idaho's telling, Congress's reference to a hospital's "available" "staff and facilities" actually means that *Idaho* law dictates how and when abortion care may be provided to those "patients." Based on this conjured formula, Idaho claims that EMTALA permits emergency abortion to be withheld under the Total Ban until a pregnant woman is close to death.

Nothing in EMTALA's plain language supports Idaho's radical attempt to re-write federal law. To the contrary, Idaho studiously ignores where the term "unborn child" is *missing* from EMTALA. "Unborn child" is excluded from sections that exclusively grant an "individual" (here, a pregnant woman) the federal right to emergency stabilizing care, and the right to accept or refuse that care. 42 U.S.C. § 1395dd(b)(1), (b)(2). Indeed, any emergency medical care for the pregnant woman *or* the fetus is applied *to her* because the fetus is in her body and it is entirely dependent upon her health and welfare. All EMTALA rights thus inure to her.

If Idaho's atextual reading is upheld, Idaho will succeed in demoting pregnant women to second-class status under EMTALA. Only pregnant women will be forced to surrender their EMTALA rights to make healthcare decisions about their bodies, and only pregnant women will have treatment guaranteed under federal law limited to *Idaho's* prohibitory terms. But the law does not easily forfeit those rights. Time and again, courts conclude that pregnant women, like everyone else, control their healthcare decisions. And

this Court has recognized that attempts to displace a pregnant woman as decision-maker about her body based on archaic notions of a pregnant woman's duty to sacrifice her body, safety, and self-determination have no place in the law.

Pregnant women stripped of their EMTALA rights under bans like Idaho's have already experienced devastating harms because of the denial of abortion care. They have endured severe hemorrhage, life-threatening infection, and the trauma of painful, hours-long vaginal delivery of a non-viable fetus. If Idaho prevails and pregnant women's EMTALA rights are allowed to vary State-to-State, these appalling, and completely avoidable, injuries will proliferate everywhere there are bans like Idaho's. And, in lock-step, denial of emergency abortions under EMTALA will contribute to this country's already-abysmal rates of maternal mortality and morbidity, which—like all reproductive harms—are racially disparate.

Finally, Idaho's Total Ban is not saved by appeals to State sovereignty. As a constitutional question, *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), left to the States the power to regulate abortion in the absence of conflicting federal law. Here, there *is* federal law that for almost 40 years has ensured that rights to emergency healthcare do not vary State-to-State. EMTALA is, in fact, tied to landmark Civil Rights legislation—the Medicare and Medicaid Act—and is part of the federal government's long-standing role in

checking State abuses and guaranteeing baseline rights across the country. The Civil Rights Movement of the 1950s and 1960s, which called to account federal lawmaking during Reconstruction, aimed to establish fundamental, nationwide guarantees of dignity, freedom, and full personhood that could not be diminished by State policy preferences. This Court should vindicate those foundational American principles and hold the Total Ban is preempted where it conflicts with EMTALA.[3]

ARGUMENT

I. IDAHO ATTEMPTS TO RE-WRITE EMTALA TO EXCLUDE PREGNANT WOMEN FROM ITS GUARANTEE OF EMERGENCY MEDICAL CARE.

EMTALA's terms are clear: only the "individual" pregnant woman who "comes to the hospital" with a health emergency has rights to stabilizing care and to make decisions about that care. 42 U.S.C. § 1395dd(b). To invade those rights and

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[3] *Amici* use "pregnant woman" in this brief, as it is the term used in EMTALA and the Total Ban. *Amici* recognize, as did this Court, that any "limits of the drafters'" views of such statutory terms "supply no reason to ignore the law's demands." *Bostock* v. *Clayton Cnty.*, 590 U.S. 644, 650–53 (2020) (Gorsuch, J.) (holding Title VII's prohibition against discrimination based on "sex" applies to sexual orientation and gender identity). Transgender and non-binary people who may become pregnant are thus equally entitled to EMTALA's guarantee of emergency abortion care and impacted by the Court's decision here.

end-run conflict preemption, Idaho distorts EMTALA's plain text to find that the two statutes "do not conflict at all." (Idaho Br. at 23.) With no textual support whatsoever, Idaho claims that (i) EMTALA "demands equal treatment for the 'unborn child,'" and thus cannot require emergency abortion care; and (ii) EMTALA's reference to a hospital's "available" "staff and facilities" actually means "permitted by State law," such that, in Idaho, emergency abortion care is permitted only to prevent the pregnant woman's death. Based on these invented theories, Idaho contends that EMTALA and the Total Ban are consistent. (Idaho Br. at 32–34; 25–30; *see* Legislature Br. at 26–29.) As shown below, this Court should reject Idaho's misinterpretations of EMTALA and contrived attempt to displace pregnant women's federal rights with Idaho's purported interests.

A. Pregnant Women Hold Guaranteed Rights To Medical Treatment Under EMTALA.

EMTALA has always made two core guarantees to an "individual" who comes to a Medicare-funded emergency room. After an initial screening to determine that she "has" an "emergency medical condition," she is entitled to be "offer[ed]": (1) treatment "to stabilize" that condition; *or* (2) safe transfer to another facility. 42 U.S.C. § 1395dd(b). Only the "individual"—here, a pregnant woman—who "has" the health emergency may accept or refuse those offers, and she alone may sue if the hospital fails to meet its EMTALA obligations to her. *Id*. § 1395dd(b),

(d)(2)(A). The pregnant woman alone enjoys these rights.

"Unborn child" is nowhere to be found in these key EMTALA provisions conferring rights to stabilizing treatment or transfer and to make informed healthcare decisions. In fact, EMTALA references "unborn child" just four times (as compared to its 52 references to the "individual" rights-holder): (1) a physician must certify that she considered the risks of transfer for both a woman in labor and the "unborn child"; (2) an "appropriate transfer" is defined as one that minimizes risks to the pregnant woman and "unborn child"; (3) "with respect to a pregnant woman," an "emergency medical condition" is defined to include severe symptoms that could place her health or the health of the "unborn child" in "serious jeopardy"; and (4) a laboring woman is deemed to have an emergency medical condition if there is inadequate time for transfer or if transfer would "pose a threat" to her health or safety or that of the "unborn child." *Id.* § 1395dd(c)(1)(A)(ii), (c)(2)(A), (e)(1)(A)(i), (e)(1)(B).[4]

None of these provisions contemplates a fetus as an entirely separate rights-holding "individual" under EMTALA. The first two merely describe transfer-related certification and standards. *Id.* § 1395dd(c)(1)(A)(ii), (c)(2)(A). The latter two are

[4] Tellingly, the remaining definitions of "emergency medical condition" never mention "unborn child." *See* 42 U.S.C. § 1395dd(e)(1)(A)(ii)–(iii) ("serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part").

definitions of "emergency medical conditions" that the pregnant "individual" alone "*has*" under EMTALA, and for which only she may accept or reject stabilizing treatment. *Id.* § 1395dd(e)(1)(A)(i), (e)(1)(B)(ii). Not one of EMTALA's four references to "unborn child" displaces the pregnant woman's EMTALA rights and decision-making authority (and none of these rights is qualified by the vagaries of State abortion laws). Instead, EMTALA recognizes that the pregnant woman alone has dominion over her life and health, and she alone is the guardian of her body and the fetus she carries within it.

EMTALA's language is clear, and this Court need go no further than EMTALA's text to reject Idaho's assertion that EMTALA and the Total Ban are somehow consistent. EMTALA's plain language and structure refute that claim.

B. Idaho's Atextual Theories Distort EMTALA's Plain Meaning.

Undaunted by EMTALA's plain language, Idaho attempts to avoid preemption by venturing that—unbeknownst to anyone until now—pregnant women in fact have severely diminished EMTALA rights because the fetus is a second, "equal" EMTALA rights-holder. (Idaho Br. at 32.) In Idaho's telling, under this supposed "equal treatment" regime, EMTALA cannot be read to require emergency stabilizing abortion care. (*Id.* at 34.) Idaho claims that when EMTALA referred to care being provided "within the staff and facilities available at the

hospital," it actually meant that any medical treatment banned by State law is not "available," and thus the Total Ban bars abortion unless and until the pregnant woman is close to death. (*Id.* at 25.) Nothing in law or logic supports Idaho's distorted interpretations of EMTALA, and these textual gymnastics only confirm that the statutes conflict.

Congress nowhere gives the fetus equal (much less paramount) rights under EMTALA and not a shred of legislative history shows any intention to do so. (*See supra* Section I.A.) Moreover, when Congress passed EMTALA in 1986, it guaranteed emergency stabilizing care to all, and specifically ensured that "women in labor" receive the emergency care they need (hence the "Labor" in EMTALA's name). *See* 131 CONG. REC. 28570 (1985) (statement of Sen. Proxmire). In 1989, Congress expanded EMTALA's protections for "women in labor" by imposing additional requirements on when and how she and the "unborn child" within her could be transferred. 42 U.S.C. § 1395dd(e)(1)(B), (e)(3); *see also* 103 Stat. 2248–49 (1989); *see supra* Section I.A. And Congress further directed in 1989 that pregnant women who "ha[ve]" *any* emergency medical condition that threatened their health or the health of their "unborn child" were entitled to stabilizing care. 42 U.S.C. § 1395dd(e)(1)(A)(i). But in Idaho's telling, every time Congress used the words "unborn child," it was secretly chipping away at pregnant women's core EMTALA rights to emergency stabilizing care and pitting them against the fetus's supposed "equal" rights. Nothing in EMTALA supports this perverse

reading of a federal law passed specifically with the care and safety of pregnant women in mind.

As to Idaho's theory that the Total Ban overrides pregnant women's federal rights based on EMTALA's reference to "staff and facilities available at the hospital," the Ninth Circuit in *Arrington* v. *Wong*, 237 F.3d 1066 (9th Cir. 2001) read this "plain language" as common sense dictates: it simply connotes a hospital's personnel and "equipment." *Id.* at 1073. Indeed, no reasonable interpretation would read it as a proxy for "under State law." Idaho's theory is not only atextual, but would convert EMTALA's nationwide guarantee of emergency stabilizing care into a patchwork of State laws. This complete inversion of EMTALA's text and purpose would not be hidden in a provision addressed to "staff and facilities." *See Puerto Rico* v. *Franklin California Tax-Free Tr.*, 579 U.S. 115, 127 (2016) ("Had Congress intended to 'alter [a] fundamental detai[l]'" of a federal statute, the Court would "expect the text . . . to say so." (citation omitted)).

The only court to squarely consider a claim like Idaho's rejected it. The Fourth Circuit in *Matter of Baby K* decided whether "within the staff and facilities available at the hospital" meant that physicians could refuse certain emergency stabilizing care under EMTALA because a Virginia law purportedly "exempt[ed]" them from providing it. 16 F.3d 590, 597 (4th Cir. 1994). But because "EMTALA does not provide [such] an exception," the Fourth Circuit held the Virginia law to be preempted and enforced the patient's EMTALA rights to stabilizing care as defined

by *federal* law. *Id.* This Court should do the same here, and reject Idaho's "wordplay" and wholesale re-imagining of a statute to try to avoid preemption. *Foster* v. *Love*, 522 U.S. 67, 72–73 (1997).

In the end, Idaho cannot explain away the head-on collision between EMTALA and the Total Ban because the two are diametrically opposed: EMTALA demands that a pregnant woman receive abortion care necessary to avoid "material deterioration" of her health in an emergency,[5] but the Total Ban *demands that her health materially deteriorate* to the point where a physician can safely say that an abortion is "necessary" to save her life, and abortion prior to that point is a crime. *Compare* 42 U.S.C. § 1395dd(b)(1)(A), (e)(3)(A), *with* Idaho Code § 18-622 § (2)(a)(i). That conflict zone—between EMTALA's broad guarantee of emergency stabilizing care and the Total Ban's requirement that a pregnant woman be close to death to qualify for an abortion—is irreconcilable and demands preemption.

[5] EMTALA does not provide "abortion enclaves" for women in Idaho (*see* Idaho Br. at 24); rather, it merely guarantees that abortion will be offered to a pregnant woman when such health care will prevent the "material deterioration" of her *emergency* medical condition. *See* 42 U.S.C. 1395dd(e)(3).

II. IDAHO'S ATTEMPT TO DISPLACE PREGNANT WOMEN'S EMTALA RIGHTS THREATENS DEVASTATING CONSEQUENCES FOR THEIR AUTONOMY, HEALTH, AND SAFETY.

If Idaho's re-write of EMTALA prevails, it will demote pregnant women to second-class status under EMTALA and cause severe harm to pregnant women's autonomy, health, and safety. *First*, Idaho will strip pregnant women of EMTALA rights guaranteed to all others, a deprivation that reflects long-rejected notions of maternal self-abnegation. *Second*, Idaho will force pregnant women to endure needless suffering and severe injury as critical abortion care is withheld while they deteriorate toward death. *Third*, the enforcement of similarly restrictive abortion bans in other States will exacerbate already alarming and racially disparate maternal mortality and morbidity rates across the U.S., with Black women increasingly and disproportionately impacted.

A. A Pregnant Woman's Rights Under EMTALA May Not Be Displaced By Idaho's Interests.

Because "every person has the right, under the common law and the Constitution, to accept or refuse medical treatment," *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990) (*en banc*), courts have long confirmed that women may not be deprived of medical decision-making rights just because they are pregnant.

Cases upholding a pregnant woman's medical decision-making rights typically involve attempts to force her to submit to unwanted medical treatment. The reasoning in those decisions, however, should guide the Court here because EMTALA expressly incorporates basic principles of informed consent, and makes clear that a pregnant woman (like everyone else) must be "offered" stabilizing treatment that she alone may accept or "refuse[]." 42 U.S.C. § 1395dd(b)(2). Idaho effectively seeks to usurp a pregnant woman's decision-making and stabilization rights under EMTALA, forcing her to forgo emergency stabilizing treatment until she is at death's door—where Idaho requires her to linger to qualify for abortion care. Idaho would thus demote pregnant women to second-class status under EMTALA, where they alone are denied the full scope of their federal rights. As in the instructive cases below, this Court should reject that outcome and preserve pregnant women's right under EMTALA to decide what will happen to their bodies.

In re A.C. is a paradigmatic, and tragic, case holding that pregnant women are the sole arbiters of medical treatment applied to their bodies. 573 A.2d at 1247, 1252. An *en banc* panel of the District of Columbia Court of Appeals vacated a court order allowing a hospital to force Angela Carder, who was terminally ill, to undergo a cesarean surgery in an effort to preserve her pre-term fetus. *Id.* at 1237–38. Ms. Carder's newborn daughter died within three hours of the forced surgery, and Ms. Carder died two days later. *Id.* at 1238. The *en banc* court

nevertheless ruled on the legality of the court order because of the potential "collateral consequences" of the wrongful decision to subject Ms. Carder to invasive surgery just because she was pregnant. *Id.* at 1241. The court rejected the notion that a pregnant woman has "an enhanced duty" to the fetus or that her medical decisions should be inferior to the fetus's purported interests. *Id.* at 1244. The court correctly held that "the decision of the [pregnant] patient . . . will control," as it would for any other patient. *Id.* at 1244, 1252.

In *In re Baby Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994), an Illinois appellate court held that a pregnant woman's decision to decline caesarean surgery "must be honored" because her "right to refuse invasive medical treatment . . . is not diminished during pregnancy." *Id.* at 401. The court reasoned that "[t]he potential impact upon the fetus is not legally relevant" because "the woman's rights can[not] be subordinated to fetal rights." *Id.* (citing *Stallman* v. *Youngquist*, 531 N.E.2d 355, 359 (Ill. 1988)). Again, "[t]he woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant." *Id.*[6]

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[6] The rule that pregnant women are not second-class patients holds true for other forms of medical care. *See In re Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (overturning court-ordered blood transfusion because the "State may not override a pregnant woman's competent . . . refusal of recommended invasive medical procedures, to potentially save

More recently, the District of Idaho held unconstitutional the Idaho Attorney General's effort to invalidate advance medical directives given by women who later become pregnant because "[w]omen do not lose the[ir] rights" in pregnancy. *Almerico* v. *Denney*, 532 F. Supp. 3d 993, 1002, 1004 (D. Idaho 2021) (citing *In re A.C.*, 573 A.2d at 1243–44). As the district court explained, if the Attorney General prevailed, "a pregnant woman about to die, whose advance directive dictated the withdrawal of all life support, would nevertheless have life support forced upon her until her baby could be delivered." *Id.* at 1002.[7]

[the fetus]"); *Muñoz* v. *John Peter Smith Hosp.*, No. 096-270080-14 (96th Dist. Ct., Tarrant Cnty. Jan. 24, 2014) (over hospital's objection, court allowed withdrawal of life support from brain-dead pregnant woman who had made clear she did not want that intervention); *see also* Vincent J. Russo & Marvin Rachlin, *Case Histories—Marlise Munoz*, N.Y. ELDER L. PRAC. § 7:53 (2023 ed.) (describing history and proceedings of the *Muñoz* case).

[7] A handful of State cases denying pregnant women the right to make medical decisions are no longer good law because they (i) were wrongly decided, *see Pemberton* v. *Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247, 1251–52 (N.D. Fla. 1999) (erroneous application of *Roe* to non-abortion case); or (ii) predate this Court's holding that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," as set forth in *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990), *see, e.g.*, *Raleigh Fitkin-Paul Morgan Mem'l Hosp.* v. *Anderson*, 201 A.2d 537 (N.J. 1964); *Matter of Jam. Hosp.*, 128 Misc.2d 1006 (Sup. Ct. Queens Cnty. 1985); *Jefferson* v. *Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (same, and decided without briefing or representation of pregnant woman in certain court proceedings).

Though Idaho does not explicitly seek to force treatment on a pregnant woman, it does seek to force her *to forgo* treatment that she is entitled to under federal law. Instead of timely access to needed emergency abortion care, the pregnant woman is subject to Idaho's restrictive terms and must wait for that care until her demise (and the demise of the fetus she carries) is otherwise inevitable. Whatever interest a State might have in regulating abortion, that interest cannot override a pregnant woman's pre-existing federal right to get the emergency medical care she needs, for herself *or* her fetus. (*See supra* Section I.A.)

Idaho's demotion of pregnant women under EMTALA evokes the invidious view that a pregnant woman's duty is to sacrifice her body, safety, and very life for her fetus. But the fact that "these sacrifices have from the beginning of the human race been endured" cannot "be grounds for the State to insist she make the sacrifice." *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U.S. 833, 852 (1992) (O'Connor, J.). A woman's decision to endanger her life or health for her fetus cannot be a compelled service to the State—it is a personal decision that only she can make.

As the *Casey* Court recognized, laws that aim to impose "'special responsibilities'" on women based on their perceived societal role as mother or wife bar women from "full and independent legal status." *Id.* at 897 (citation omitted). These misogynist and "ancient notions about women's place in the family

and under the Constitution . . . have long since been discredited." *Gonzales* v. *Carhart*, 550 U.S. 124, 185 (2007) (Ginsburg, J., dissenting). Thus, in *Casey*, the Court held that "[a] husband's interest in the life of the child his wife is carrying" does not allow a State to "[give] a man the kind of dominion over his wife that parents exercise over their children." 505 U.S. at 898. Idaho's claim to that same infantilizing dominion over a pregnant woman exercising her federal EMTALA rights should equally be rejected.

As shown below, beyond demotion to second-class status, Idaho's insistence (and, by extension, the insistence of other States with similar abortion bans) that pregnant women with an emergency medical condition sacrifice their health and risk their lives before being allowed the stabilizing abortion care that EMTALA guarantees is already causing devastating harm.

B. If Not Preempted Where It Conflicts With EMTALA, The Total Ban Will Cause Pregnant Women With Medical Emergencies To Suffer Severe Harm.

"[T]he longer emergency abortions are delayed, the greater the risk that lifesaving interventions might not be effective and pregnant individuals could experience morbidity and mortality." Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, 328 J. AM. MED. ASS'N 1691, 1691 (Nov. 1, 2022). But a pregnant woman trapped in the "conflict zone" between

EMTALA and the Total Ban will have abortion care *deliberately* delayed until she is so close to death that a healthcare provider can safely say abortion is "*necessary*" to save her life. Forcing a pregnant woman's health to deteriorate until healthcare providers believe they can stabilize her without risking ruinous consequences for themselves is a perversion of EMTALA's core guarantees.

The brutality of Idaho's claims cannot be overstated. Idaho seeks to strip away pregnant women's federal rights and compel them to get so sick that they are close to death, in forced fealty to the Total Ban. As the record here demonstrates, denying pregnant women federally-guaranteed abortion care based on a State abortion ban would cause pregnant women to suffer devastating and lasting injuries. These harms are all the more egregious because they are pointless—"fetal life" is not served by pushing a pregnant woman to the brink of death to qualify for needed healthcare because where that woman goes, the fetus follows. Indeed, the "necessary to prevent death" exception that Idaho packages under a "Defense of Life" banner only risks the *mutual* demise of the pregnant woman and fetus, and to no end. *See generally Gonzales*, 550 U.S. at 181 (Ginsburg, J., dissenting) (observing irrationality of law that does "nothing to preserv[e] fetal life," yet bars a woman from obtaining medical procedure that would "best protect her").

The record in this case vividly shows that abortions are necessary, health- and life-saving care

for pregnant women, and that confusion in Idaho about the Total Ban and EMTALA is new and avoidable. For example, prior to the Total Ban taking effect, a pregnant woman had an infection of her womb at 18 weeks that put her at risk of severe sepsis. An emergency abortion was performed to avoid risk of kidney failure, blood clotting disorders, future infertility, and removal of her uterus. (J.A. 373–74.) Yet another pregnant woman suffered uncontrollable vaginal bleeding at 19 weeks, causing her to go into shock due to blood loss. Consistent with longstanding EMTALA practice, detectable fetal cardiac activity did not prevent the pregnant woman from getting "[t]he only medically available tool to stop the bleeding [which] was termination of the pregnancy." (J.A. 374–75.) And another pregnant woman experienced severe preeclampsia and skyrocketing blood pressure that put her at risk of a seizure. Because abortion was "[t]he only cure for [her] preeclampsia," she received that care. (J.A. 376–77.) But shortly after *Dobbs* was issued, a pregnant woman suffering from premature rupture of her amniotic sac at 19 weeks had her abortion unnecessarily delayed, leading to uncontrollable bleeding, the loss of almost half her blood volume, and a transfusion. (J.A. 356–59.)

Unless preempted where it conflicts with EMTALA, the Total Ban will put the lives of pregnant women in Idaho with medical emergencies on a razor's edge—they will be denied their federal rights to stabilizing treatment and forced to *destabilize* until they are so mortally ill that Idaho says they are allowed healthcare. Idaho's only response to this

unconscionable degradation is to claim that no one should worry about pregnant women dying because the *Idaho Legislature's expert* concluded, *post hoc*, that the physician declarations here reflect sufficiently "life-threatening" circumstances so as to permit an abortion, as though that ends the matter. (Legislature Br. at 12–15; *see* J.A. 512–26.)

Idaho misses the point: the experts in this action—and healthcare providers on the ground—*cannot agree* about what constitutes a "close to death" condition or when abortion care becomes "necessary" to avoid the pregnant woman's death and their own criminal prosecution. The pregnant woman, meanwhile, is left to suffer in terror needlessly while healthcare providers, attorneys, and hospital administrators debate whether she is sick enough that they can safely say that her demise is inevitable. (*See* J.A. 362–64.)

The Idaho Supreme Court's holding in *Planned Parenthood Great Northwest* v. *State*, 522 P.3d 1132 (Idaho 2023) is no safe harbor to an Idaho physician facing the decision whether to offer an abortion. The court held that the Total Ban's "necessary to prevent death" exception imposed "a subjective standard, focusing on the particular physician's judgment." *Id.* at 1203. But physicians defending a criminal charge for violating the Total Ban must defend that judgment against the *post hoc* second-guessing of prosecutors, and would seek to back up their judgment with the views of other physicians, administrators, and lawyers, given the risks of imprisonment and loss of

their medical license and livelihood. (J.A. 362–64.) Understandably, many Idaho healthcare providers will not take these risks. And even if they do, pregnant women will be trapped in a potentially deadly waiting game before they receive needed—and now life-saving—care.

Allowing the Total Ban to revoke pregnant women's EMTALA rights will take (and, in some States, has already taken) pregnant women back decades to the "medically indefensible" pre-EMTALA *status quo*, where pregnant women were "turned away" from emergency rooms without stabilizing care. 131 CONG. REC. E5520–21 (daily ed. Dec. 10, 1985) (statement of Rep. Stark). This Court should reject that outcome.

C. If Not Preempted Where It Conflicts With EMTALA, The Total Ban Will Set A Precedent And Cause Maternal Mortality And Morbidity Rates In The United States To Worsen.

If Idaho prevails, the impact will be felt most severely in States with extreme abortion bans, *i.e.*, Idaho and 13 States that ban abortion from conception and have inadequate exceptions to preserve pregnant women's health ("Total Ban States").[8] Because of these bans' similarities, a decision for Idaho will set a

[8] Total Ban States include Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia.

precedent that will effectively exempt all Total Ban States' abortion laws from EMTALA's preemptive effect, deny women with pregnancy-related emergencies critical treatment, and cause maternal mortality and morbidity rates to rise.

Pregnancy-related deaths in the U.S. have been rising for decades.[9] In 2021, the most recent year for which the Centers for Disease Control and Prevention ("CDC") data is available, the CDC reported that the U.S. maternal mortality rate ("MMR")[10] climbed to 32.9 deaths per 100,000 live births, up from 23.8 in

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[9] *See Pregnancy Mortality Surveillance System*, CDC (Mar. 23, 2023), https://tinyurl.com/mpu4umr7 (upward trend in pregnancy-related mortality from 1987-2019, defined as "a death while pregnant or within [one] year of the end of pregnancy from any cause related to or aggravated by the pregnancy").

[10] Maternal deaths are defined as "deaths of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes"; the maternal mortality rate is measured in maternal deaths per 100,000 live births. *See Maternal Deaths and Mortality Rates: Each State, the District of Columbia, United States, 2018-2021*, CDC, https://tinyurl.com/5n6vpua4 (last visited Mar. 26, 2024). Maternal morbidity rates are "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health." *Severe Maternal Morbidity in the United States*, CDC (July 3, 2023), https://tinyurl.com/yv4mnwrr.

2020.[11] The U.S. MMR is two-to-ten times the comparable MMRs of peer countries.[12]

The impact of these worsening rates will be disproportionate geographically and racially. Six Total Ban States have the highest MMRs in the country, with close to *double* the national average.[13]

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[11] Donna Hoyert, *Maternal Mortality Rates in the United States, 2021*, CDC (Mar. 16, 2023), https://tinyurl.com/mudentux. *Amici* are aware of a recent study estimating the U.S. MMR at 10.4 for 2018-2021 using an alternative calculation method. *See* K.S. Joseph et al., *Maternal Mortality in the United States: Are the High and Rising Rates Due to Changes in Obstetrical Factors, Maternal Medical Conditions, or Maternal Mortality Surveillance?*, AM. J. OBSTETRICS & GYNECOLOGY, Mar. 12, 2024, at 1.e1. The authors acknowledged their "reliance on cause-of-death data from death certificates[could] lead to an underestimation of maternal mortality." *Id.* at 1.e11. And even if the U.S. MMR were halved, it would still be *double-to-triple* the rates of peer countries. This study also found that the MMR for Black women was "disproportionately high[]" and more than twice the rate of white women. *Id.* at 1.e8–9. The CDC "disagrees with the [study's] findings" because the researchers' methods "are known to produce a substantial undercount of maternal mortality." Andrea Rice, *Maternal Deaths May Be Overestimated, But There's Still a Maternal Health Crisis*, HEALTHLINE (Mar. 15, 2024), https://tinyurl.com/3sctv8st.

[12] For example, the World Health Organization compared 2020 MMR data and estimated the U.S. MMR was 21, Canada's was 11, the U.K.'s was 10, Germany's was 4, and Norway's was 2. *See Trends in Maternal Mortality 2000 to 2020*, UNICEF, Annex 4 (2023), https://data.unicef.org/resources/trends-in-maternal-mortality-2000-to-2020/ (click "Read the report").

[13] State-by-state CDC MMR data is available as an average for the time period of 2018-2021. For this time period the U.S.

These Total Ban States are in the American South where Black people constitute a significant portion of the population[14] and Black women already experience disproportionate MMRs. Louisiana, Mississippi, and Missouri have reported MMRs for Black women that are at least *four times* higher than for white women,[15] and the 2021 national MMR for Black women is *2.6 times* the rate for white women.[16] *See also Dobbs*, 597 U.S. at 396 n.13 (Breyer, Sotomayor, and Kagan, J.J., dissenting) (discussing racial disparities in maternal mortality and morbidity).

MMR was 23.5, and the nation's highest MMRs were: Arkansas (43.5), Mississippi (43.0), Tennessee (41.7), Alabama (41.4), Louisiana (39.0), and Kentucky (38.4). *See Maternal Deaths and Mortality Rates*, CDC, *supra* note 10. Four other Total Ban States had MMRs above the national average. *Id.* (Indiana (31.1), Missouri (25.7), Oklahoma (30.3), and Texas (28.1)).

[14] *See Race and Ethnicity in the United States: 2010 Census and 2020 Census*, U.S. CENSUS BUREAU (Aug. 12, 2021), https://tinyurl.com/4bw8zkh9.

[15] *See Addressing Disparities in Maternal and Child Health Outcomes for African Americans*, LA. DEP'T OF HEALTH, 2 (Sept. 2019), https://tinyurl.com/2pw2ybuj; *Mississippi Maternal Mortality Report 2016-2020*, MISS. STATE DEP'T OF HEALTH, 7 (Dec. 2023), https://tinyurl.com/3nvyf2d5; *Missouri Pregnancy-Related Mortality Review, 2018 Annual Report*, MO. DEP'T OF HEALTH & SENIOR SERVS., 5 (2021), https://tinyurl.com/2e2buc5a.

[16] Hoyert, *supra* note 11. Black women are also twice as likely as white women to suffer severe maternal morbidity. *See Executive Brief: Health of Women and Children Report 2022*, UNITED HEALTH FOUND., 4, https://tinyurl.com/uyekfjex (last visited Mar. 26, 2024).

These gross disparities persist even when controlling for underlying factors like education and income, "pointing to the roles racism and discrimination play in driving disparities." Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KFF (Nov. 1, 2022), https://tinyurl.com/3n9wbcux. These statistics reflect the enduring impact of both racism and slavery, which have primed poor maternal health outcomes for Black women in particular. *See, e.g.*, Juanita J. Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. WOMEN'S HEALTH 212, 213 (2021) ("[h]ealth inequality among Black women is rooted in slavery," and their treatment by the "medical establishment, particularly in gynecology, contributes to the[ir] present-day health disadvantages"); Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 J. L., MED., & ETHICS 506, 512 (2020) (finding that physicians tend to "ignor[e] [Black women's] expressions of pain and discomfort . . . [and] discount[] treatment considerations and preferences offered by the patient," leading to "maternal deaths and injuries").

A ruling for Idaho restricting access to emergency abortion care will only exacerbate challenges already faced by women of color[17] in accessing prenatal healthcare, with Black women in the American South being disproportionately impacted. Inevitably, such a ruling would also

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17 *See* Hill, *supra*.

accelerate the increase of the United States' already dismal MMR and maternal morbidity rates.

III. PREEMPTING THE TOTAL BAN IS CONSISTENT WITH THE LONG HISTORY OF FEDERAL PROTECTION OF FOUNDATIONAL RIGHTS.

"[S]ome fundamental aspects of personhood, dignity, and the like do not vary from State to State, and demand a baseline level of protection." *McDonald* v. *City of Chicago, Ill.*, 561 U.S. 742, 880 (2010) (Stevens, J., dissenting). Once Congress sets that baseline, a State may not legislate below it. EMTALA set a nationwide federal "floor" for emergency medical care, and, by extension, for the autonomy, dignity, and safety that access to healthcare protects. Under basic principles of federalism, Idaho may not lower that floor by criminalizing emergency abortion care that EMTALA guarantees. Congress did not make "brink of death" a qualifying condition for anyone to get EMTALA care, and Idaho cannot override Congress by reading in that qualifier just for pregnant women.

EMTALA is consistent with the federal government's long history of protecting foundational rights against State abuses. Indeed, Congress enacted EMTALA under the Social Security Act, and imposed conditions for emergency stabilizing care on all hospitals that accept federal funding under the Medicaid and Medicare Act of 1965, landmark Civil Rights-era legislation that helped to end segregation in many U.S. hospitals. *See* Vann R. Newkirk II, *The*

Fight for Health Care Has Always Been About Civil Rights, THE ATLANTIC (June 27, 2017), https://tinyurl.com/mr2axyd2 (describing the Civil Rights Act and Medicare and Medicaid Act as "complementary pieces of a grand civil-rights strategy"). During the Civil Rights Movement, Congress demonstrated that federal laws—like the Medicare and Medicaid Act of which EMTALA is a part—are essential to guaranteeing a basic floor of dignity-affirming rights nationwide.

When Congress enacted EMTALA in 1986, it reinforced the health-affirming guarantees of the Medicare and Medicaid Act. It promised emergency stabilizing care to anyone who presents at a Medicare-participating hospital—the vast majority of hospitals in the country. This guarantee addressed widespread denials of emergency stabilizing care, and what Congress described as the "most egregious abuse[]" by "hospitals with emergency rooms"—the refusal to "provide emergency treatment for . . . women in labor." *See* 131 CONG. REC. 28570 (1985) (statement of Sen. Proxmire).

EMTALA thus "sen[t] a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." 131 CONG. REC. 28568 (1985) (statement of Sen. Durenberger). Because it guarantees a nationwide federal right, EMTALA belongs to the long tradition of the federal government protecting foundational rights—here,

ensuring that no one is denied access to emergency healthcare, including needed abortion care.[18]

This practice of federal lawmaking to protect foundational rights reaches as far back as the post-Civil War Reconstruction Amendments and corresponding federal statutes. These federal laws sought to prohibit States from weaponizing their sovereignty to exclude formerly enslaved people from civic life, and from the personal freedoms and human dignity that civic life entails.

Following the Civil War and the formal end of slavery, States had tremendous power without federal oversight, and a number abused that power to pass racist laws, such as "Black Codes," that "reestablish[ed] slavery 'in all but its name.'" Eric Foner, *A Short History of Reconstruction* 93, 97 (Abr. ed. 1990). The Reconstruction Amendments and federal laws passed to enforce them reflect Congress's

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[18] That EMTALA was passed pursuant to Congress's Spending Clause power, U.S. Const. art I, § 8, cl. 1, is of no moment—it has preemptive force under the Supremacy Clause, U.S. Const. art. VI, cl. 2, as explained by Respondent. (Respondent Br. at 45–47.) Additionally, like Congress's Section 5 enforcement power, U.S. Const. amend. XIV, § 5, Congress has many times used its Spending Clause power "to eradicate invidious discrimination." *See Cummings* v. *Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 231, 235–36 (2022) (Breyer, J., dissenting) (citing, *e.g.*, Title IX, 20 U.S.C. § 1681 (barring sex discrimination in education programs) and the Rehabilitation Act of 1973, 29 U.S.C. § 794 (forbidding exclusion of individuals with disabilities), and comparing those laws to the Civil Rights Act of 1964, which also sought "the vindication of human dignity" (citation omitted)).

determination that basic dignity-affirming rights cannot vary depending on where a person lives in this country. *See* Rebecca E. Zietlow, *Juriscentrism and the Original Meaning of Section Five*, 13 TEMP. POL. & C.R. L. REV. 485, 505 (2004). The Reconstruction Amendments thus "recalibrated the balance of power between the federal government and the states" and emphasized the vital role of federal lawmaking. John F. Kowal & Wilfred U. Codrington III, *The People's Constitution* 118 (2021).

Importantly, reproductive control was an inherent component of the subordination and dehumanization that abolition and Reconstruction intended to address. *See* Peggy Cooper Davis, *The Reconstruction Amendments Matter When Considering Abortion Rights*, THE WASHINGTON POST (May 3, 2022), https://tinyurl.com/2s3zyj2r. This Court should not accept a misinterpretation of EMTALA or federalism principles that erodes a pregnant woman's healthcare rights and breaks from a long history of protecting foundational rights. The lessons of Reconstruction remain vital, and as Justice Jackson emphasized: "History speaks. In some form, it can be heard forever." *Students for Fair Admissions, Inc.* v. *President and Fellows of Harvard Coll.*, 600 U.S. 181, 393 (2023) (Jackson, J., dissenting).

Ignoring this history, Idaho claims that EMTALA improperly invades its sovereignty and its claimed police power to criminalize emergency abortion care post-*Dobbs*. (*See* Idaho Br. at 40; Legislature Br. at 40.) Idaho seeks—for the first time in EMTALA's

history—to carve out a single group from a law otherwise applicable to all. If a pregnant woman's right to stabilizing care under EMTALA varies drastically from one State to the next, so too does the health, safety, and full personhood of the woman who seeks that care.

Allowing Idaho to strip pregnant women of their EMTALA rights evokes the close histories of using State law to deny people fundamental guarantees of personhood—the basic right to self-determination and bodily autonomy. This is an outcome Congress has consistently sought to prohibit and one that is at odds with America's most basic democratic principles. Idaho's claims are an affront to the fundamental precepts of federalism and to what it means to be free in America, and should be rejected.

CONCLUSION

For the foregoing reasons, this Court should hold that the Total Ban is preempted to the extent it conflicts with EMTALA and purports to ban emergency stabilizing abortion care.

Respectfully submitted,

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