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 OF AMERICA

STATE OF IDAHO, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd, preempts Idaho law in the narrow but important circumstance where terminating a pregnancy is required to stabilize an emergency medical condition that would otherwise threaten serious harm to the pregnant woman's health but the State prohibits an emergency-room physician from providing that care.

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OPINIONS BELOW

The order of the court of appeals granting a stay (J.A. 690-708) is reported at 83 F.4th 1130. The order of the court of appeals vacating the stay and granting rehearing en banc (J.A. 709, 710-711) is reported at 82 F.4th 1296. The opinion and order of the district court (J.A. 620-656) is reported at 623 F. Supp. 3d 1096.

JURISDICTION

The district court entered a preliminary injunction on August 24, 2022 (J.A. 620-656) and denied reconsideration on May 4, 2023 (J.A. 660-671). Petitioners filed notices of appeal on June 28 and July 3, 2023 (J.A. 672, 679). The court of appeals' jurisdiction rests on 28 U.S.C. 1291. On November 20, 2023, petitioners applied to this Court for a stay. On January 5, 2024, the Court stayed the preliminary injunction, treated the applications as petitions for writs of certiorari before judgment, and granted the petitions. The Court's jurisdiction rests on 28 U.S.C. 1254(1) and 2101(e).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are reproduced at App., *infra*, 1a-12a.

STATEMENT

This case concerns whether a State can prevent pregnant women from receiving the essential emergency medical treatment that federal law guarantees to all Americans. Under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd *et seq.*, a hospital that participates in Medicare must offer stabilizing treatment to any patient with an emergency condition that seriously threatens her life or health. 42 U.S.C. 1395dd(b)(1). When a pregnancy is healthy, EMTALA has no application. But pregnant women can suffer dangerous conditions that require immediate medical treatment to prevent death or serious injury, including organ failure or loss of fertility. And in some tragic cases, the required stabilizing care—the only treatment that can save the woman's life or prevent grave harm to her health—involves terminating the pregnancy.

Under those narrow but critically important circumstances, a straightforward application of EMTALA's text requires the hospital to offer that essential medical care. The Department of Health and Human Services (HHS) has maintained and enforced that interpretation across the administrations of George W. Bush, Barack Obama, Donald Trump, and Joe Biden. And the courts, the medical community, and Congress have long shared the same understanding.

Before this Court's decision in *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), there was little occasion to consider how EMTALA interacts with state abortion laws because States generally could not prohibit termination of a pregnancy in the circumstances where EMTALA would require that care. Even after *Dobbs*, States that have adopted more restrictive abortion laws have usually included exceptions permitting termination of a pregnancy to avoid serious harm to the pregnant woman's health. But a handful of States, including Idaho, have prohibited such care even in the emergency circumstances where EMTALA requires it.

Although that particular conflict is new, EMTALA's plain text resolves it: State law is preempted "to the extent"—and only to the extent—it "directly conflicts with a requirement" of EMTALA. 42 U.S.C. 1395dd(f). Idaho's prohibition on abortion is thus enforceable in nearly all of its applications. But Idaho cannot prohibit the emergency care that federal law requires in the narrow circumstances covered by EMTALA.

A. Legal Background

1. Medicare is a federally subsidized health insurance program for the elderly and certain individuals with disabilities. Participation is voluntary, but

hospitals that choose to participate must comply with certain conditions. See *Biden* v. *Missouri*, 595 U.S. 87, 90 (2022) (per curiam). Among other things, hospitals with emergency departments must abide by EMTALA. 42 U.S.C. 1395cc(a)(1)(I)(i).

EMTALA was enacted in 1986 to address concerns that hospitals were engaged in "patient dumping" by discharging or transferring critically ill patients who lacked insurance rather than providing "the care they need." 131 Cong. Rec. 28,569 (1985) (Sen. Kennedy). As then-Senate Majority Leader Dole explained, "our citizens stake their very lives on the availability and accessibility of emergency hospital care"—yet hospitals, often for financial reasons, were "refus[ing] to initially treat or stabilize an individual with a true medical emergency." *Ibid.* Congress determined that Medicare should not "do business" with a hospital that "turns its back on an emergency medical situation." *Id.* at 28,568 (Sen. Durenberger).

Consistent with that objective, EMTALA guarantees essential emergency care by establishing a national minimum standard for hospitals funded by Medicare. EMTALA provides that when "any individual * * * comes to a [participating] hospital" with an "emergency medical condition," the hospital must offer such treatment "as may be required to stabilize the medical condition." 42 U.S.C. 1395dd(b)(1). The "individual" must be informed of risks and benefits and can give "informed consent to refuse such examination and treatment." 42 U.S.C. 1395dd(b)(2).

An individual has an "emergency medical condition" if "the absence of immediate medical attention could reasonably be expected to result in": (i) "placing the health of the individual (or, with respect to a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy"; (ii) "serious impairment to bodily functions"; or (iii) "serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). "[T]o stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. 1395dd(e)(3)(A). And a "transfer" is defined to include a discharge. 42 U.S.C. 1395dd(e)(4).

Hospitals that violate EMTALA are subject to suits by injured patients, 42 U.S.C. 1395dd(d)(2); civil penalties, 42 U.S.C. 1395dd(d)(1); and, potentially, the loss of Medicare funding, 42 U.S.C. 1395cc(b). EMTALA also includes an express preemption provision specifying that the statute "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement" of EMTALA. 42 U.S.C. 1395dd(f).

2. This case concerns Idaho Code § 18-622, which generally makes it a crime to terminate a pregnancy. In its current form, Section 18-622 allows only those "abortion[s] * * * necessary to prevent the death of the pregnant woman," *id.* § 18-622(2)(a)(i); to terminate "an ectopic or molar pregnancy," *id.* § 18-604(1)(c); or to terminate certain pregnancies resulting from rape or incest, *id.* § 18-622(2)(b). Otherwise, it is a felony punishable by two to five years' imprisonment to "perform[]," "attempt[] to perform," or "assist[] in performing or attempting to perform" an "abortion." *Id.* §§ 18-622(1), 18-604(1) and (11). Providers can also lose their medical licenses. *Id.* §§ 18-622(1). "Abortion" is defined as "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." *Id.* § 18-604(1).[1]

B. Proceedings Below

1. In August 2022, the United States filed this suit against Idaho, arguing that Section 18-622 is preempted in the narrow circumstances when it directly conflicts with EMTALA. J.A. 20-21. Invoking "basic preemption principles," the district court enjoined enforcement of Section 18-622 "as applied to medical care required by [EMTALA]." J.A. 637, 656.

First, the district court held that in some circumstances "it is impossible to comply with both statutes." J.A. 638. "[W]hen pregnant women come to a Medicare-funded hospital with an emergency medical condition," EMTALA obligates the hospital to provide stabilizing treatment, which sometimes includes "abortion care." J.A. 638. But Section 18-622 allows pregnancy termination only when "*necessary* to prevent the patient's death." J.A. 639. EMTALA's requirement to provide care is "broader" than Section 18-622's necessary-to-prevent-death exception on "two levels": It requires care (i) "to prevent injuries that are more wide-ranging than death," and (ii) "when the patient could 'reasonably be expected' to suffer injury." J.A. 639-640.

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[1] As originally enacted, Section 18-622 framed the necessary-to-prevent-death exception as an affirmative defense and did not explicitly exclude ectopic pregnancies. See J.A. 683-689. After the entry of the preliminary injunction here, the Idaho Supreme Court construed the law to exclude ectopic pregnancies, *Planned Parenthood Great Nw.* v. *Idaho*, 522 P.3d 1132, 1203 (2023), and Idaho then amended the law to its current form.

Based on declarations from medical experts, the district court found that pregnancy termination can be the EMTALA-required stabilizing treatment for several emergency conditions in circumstances where that treatment would be a felony under Idaho law. Those conditions include:

- rupture of the amniotic sac ("preterm premature rupture of the membranes"), which can result in infection, sepsis, or organ failure;
- "placental abruption," which can result in "uncontrollable bleeding" or "organ disfunction";
- "uncontrollable uterine hemorrhage," which can "requir[e] hysterectomy" or result in "kidney failure requiring lifelong dialysis"; and
- "preeclampsia," which can result in the "onset of seizures" or "hypoxic brain injury."

J.A. 620-621, 628. The court held that EMTALA preempts Section 18-622 in circumstances where it "requires the provision of care and state law criminalizes that very care." J.A. 638.

Second, the district court held that Section 18-622 "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." J.A. 643 (citation omitted). "[E]ven if it were theoretically possible to simultaneously comply with both laws," Section 18-622 would frustrate EMTALA's guarantee of "a bare minimum of emergency care." J.A. 643-644. The court explained that Section 18-622 would deter EMTALA-required stabilizing care because it would often require, in an emergency, a "medically impossible" determination that termination of the pregnancy is "*necessary* to prevent the patient's death." J.A. 639, 647 (citation omitted).

2. Petitioners appealed, and a panel of the Ninth Circuit granted a stay pending appeal. J.A. 694-704. The panel believed that Section 18-622 does not conflict with EMTALA because EMTALA "does not set standards of care or specifically mandate that certain procedures, such as abortion, be offered"; rather, in the panel's view, EMTALA simply "'prevent[s] hospitals from dumping indigent patients.'" J.A. 696-698 (brackets and citation omitted). The panel also concluded that Section 18-622 does not pose an obstacle to accomplishment of EMTALA's purpose on the theory that Congress enacted EMTALA "to respond to the specific problem of hospital emergency rooms refusing to treat patients who were uninsured." J.A. 703 (citation omitted).

3. The Ninth Circuit granted rehearing en banc, vacating the panel opinion and reinstating the preliminary injunction. J.A. 709. The en banc court later denied a stay pending appeal. J.A. 710-711.

SUMMARY OF ARGUMENT

EMTALA's promise is limited but profound: No one who comes to an emergency room in need of emergency medical care should be denied the treatment required to stabilize her condition. For some pregnant women suffering tragic emergency complications, the only care that can prevent grave harm to their health is termination of the pregnancy. In those circumstances, EMTALA requires participating hospitals to offer such care—yet Idaho law forbids it. EMTALA accordingly preempts state laws like Section 18-622 to the extent they prohibit the essential medical care required by federal law.

A. This case is about the meaning of the stabilization requirement at the heart of EMTALA. Congress directed covered hospitals to offer the treatment required

"to stabilize" an "emergency medical condition"—that is, "to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result" from a discharge or transfer. 42 U.S.C. 1395dd(b)(1) and (e)(3). By its terms, that directive requires covered hospitals to provide treatment that satisfies the statutory standard.

When a pregnant woman presents with an emergency medical condition, there are circumstances where the only care that will stabilize the condition and thus satisfy EMTALA's standard is termination of the pregnancy. In those cases, EMTALA requires hospitals to offer that stabilizing care. That interpretation is in no sense novel. HHS, courts, providers, and Congress itself have long recognized that EMTALA requires hospitals to offer pregnancy termination when required to save a woman's life or prevent grave harm to her health.

B. As relevant here, Section 18-622 prohibits termination of a pregnancy unless it is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a). That prohibition directly conflicts with EMTALA when termination is required to stabilize a pregnant woman whose emergency medical condition threatens serious harm to her health but would not (absent further deterioration) cause her death. As the record demonstrates, that gap has devastating real-world consequences. Many pregnancy complications do not pose a threat to the woman's life when she arrives at the emergency room—but delaying care until necessary to prevent her death could allow her condition to deteriorate, placing her at risk of acute and long-term complications.

Although the conflict between EMTALA and Section 18-622 has life-altering consequences in the cases where

it is relevant, those cases are rare. EMTALA requires a hospital to offer pregnancy termination only when that care is required to stabilize an emergency medical condition. If the condition arises later in pregnancy and the fetus can be delivered safely, Idaho law does not conflict with EMTALA. Cases implicating the conflict thus typically occur before viability. But in many such cases, the same condition that threatens the pregnant woman's health also means the fetus will not survive even if the woman is denied immediate care and the pregnancy continues. Delaying care until the woman's condition deteriorates and the doctor can say that termination is necessary to prevent her death, as Idaho law requires, stacks tragedy upon tragedy with little additional likelihood of fetal survival.

C. Petitioners' interpretation of EMTALA has shifted during this litigation, and even now they have not settled on what they think the Act's stabilization requirement means. But each of the three interpretations they posit contradicts the Act's plain text. And petitioners' various extra-textual arguments provide no justification for departing from a natural reading of the statute.

First, petitioners assert that EMTALA never requires *any* specific treatment because it prohibits only discrimination against the uninsured. That flatly contradicts the statutory text. EMTALA imposes a substantive federal standard requiring covered hospitals to offer "any individual" with an emergency medical condition "such treatment as may be required to stabilize the medical condition." 42 U.S.C. 1395dd(b). In *Roberts* v. *Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per curiam), this Court emphatically rejected a similar attempt to transform EMTALA into a nondiscrimination

rule. Petitioners' interpretation fundamentally departs from the way EMTALA has been understood and enforced for decades—not just in the context of pregnancy termination, but in all of its applications.

Second, petitioners suggest that even if EMTALA sometimes requires particular stabilizing treatments, it never requires treatments that violate state law. That interpretation likewise has no textual basis. And it would invert EMTALA's express preemption provision, which makes clear that when state law conflicts with EMTALA, the state law must give way.

Third, petitioners assert that the stabilizing care required by EMTALA never includes termination of a pregnancy. Once more, that limit has no basis in text. EMTALA treats pregnancy termination the same as any other stabilizing care: It must be provided if, and only if, it is required to assure that no material deterioration of the individual's condition is likely to occur. 42 U.S.C. 1395dd(e)(3). In 1989, Congress amended EMTALA to make clear that it applies when a pregnant woman's medical condition seriously threatens the health of her "unborn child" even if her own health is not at risk. 42 U.S.C. 1395dd(e)(1)(A)(i). But all of EMTALA's duties run to the "individual" seeking care —that is, the pregnant woman. And nothing in the 1989 amendment altered a hospital's obligation to offer stabilizing care when termination of the pregnancy is required to save the woman's life or prevent serious harm to her health. On petitioners' contrary reading, a State could categorically prohibit pregnancy termination and EMTALA would not require treatment even if a pregnant woman in medical crisis arrived at a hospital urgently needing termination to save her life.

Finally, petitioners seek to justify their atextual reading of EMTALA by invoking other statutes, the presumption against preemption, novel constitutional theories, and the major-questions doctrine. Those arguments are unpersuasive on their own terms, and cannot override a straightforward application of EMTALA. The Act does not displace States' judgment on abortion policy in general, and it has no effect on Section 18-622 in the vast majority of its applications. But EMTALA's plain text promises essential emergency care to all Americans. And when a pregnant woman experiences an emergency medical condition that makes continuing the pregnancy a grave threat to her life or health, pregnancy termination is essential medical care.

ARGUMENT

Section 18-622 directly conflicts with EMTALA—and is thus preempted—in the limited but critically important circumstances where (i) pregnancy termination is the only way to stabilize an emergency condition that threatens serious harm to a pregnant woman's health, but (ii) Section 18-622 prohibits that treatment because the provider cannot determine that such care is "necessary" to prevent the pregnant woman's "death."

A. EMTALA Requires Hospitals To Offer Pregnancy Termination When That Care Is Required To Stabilize An Emergency Medical Condition

This case is about the meaning of EMTALA's stabilization requirement. As with any question of statutory interpretation, the analysis "begins with the text." *Ross* v. *Blake*, 578 U.S. 632, 638 (2016). If that text is "unambiguous," then "this first canon is also the last: 'judicial inquiry is complete.'" *Connecticut Nat'l Bank* v. *Germain*, 503 U.S. 249, 254 (1992) (citation omitted). Those

familiar principles control here. EMTALA's operative text unambiguously requires covered hospitals to provide the treatment required to reasonably assure that a patient's emergency condition does not materially deteriorate. In some cases, the only treatment that will save a pregnant woman's life or prevent grave harm to her health is termination of her pregnancy. EMTALA therefore requires covered hospitals to offer that treatment—as HHS, the courts, the medical community, and Congress have long understood.

1. EMTALA requires a covered hospital to offer essential emergency care to all individuals who come to the hospital in need of such care:

> **(b) Necessary stabilizing treatment for emergency medical conditions and labor**
>
> **(1) In general**
>
> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide * * * —
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition.

42 U.S.C. 1395dd(b).

The plain language of Section 1395dd(b) makes clear that a hospital violates EMTALA if an individual presents with an emergency medical condition and the hospital fails to offer the necessary stabilizing treatment. Congress did not simply require *some* treatment or *the same* treatment offered to other patients. Instead,

Congress articulated a substantive standard by mandating, "within the staff and facilities available," "such treatment as may be required to stabilize" the condition. 42 U.S.C. 1395dd(b). And Congress used specific medical terms to define what it means "to stabilize" a patient: "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 a transfer or discharge. 42 U.S.C. 1395dd(e)(3)(A); see 42 U.S.C. 1395dd(e)(4).

2. For some pregnant women suffering from emergency medical conditions, pregnancy termination is the only possible stabilizing treatment and so is required by EMTALA. Congress expressly contemplated that a "pregnant woman" could be among the "individual[s]" experiencing an "emergency medical condition." 42 U.S.C. 1395dd(e)(1)(A)(i) and (B). And Congress defined such a condition to include "a medical condition manifesting itself by acute symptoms of sufficient severity" that "the absence of immediate medical attention could reasonably be expected" to result in "serious jeopardy" to the individual's "health," "serious impairment to bodily functions," or "serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). Emergency complications that arise during pregnancy can satisfy that standard, including premature preterm rupture of membranes, placental abruption, pre-eclampsia, eclampsia, spontaneous miscarriage with detectable fetal heart rate, and intrauterine infection. J.A. 620-621; see J.A. 24-44, 354-376, 591-619 (physician declarations).

When a woman presents with one of those emergency conditions, "there are situations where pregnancy termination is the only medical intervention that

can preserve [the] patient's health or save their life." J.A. 373; accord J.A. 29-30, 356, 367, 606. In some cases, the patient will likely die without such care. In others, the patient may not face an imminent threat to her life but will be at risk of serious harms to her health absent immediate pregnancy termination, such as loss of fertility; hysterectomy; sepsis; clotting disorder; heart attack; coma; stroke; cardiovascular, immune, or platelet dysfunction; and renal, liver, or other organ failure. J.A. 35-38, 41, 297-298, 373-374, 599-603, 616-617, 621, 629-630.

Experience in Idaho before Section 18-622 illustrates the point. Although many hospitals "were not offering 'elective terminations' of pregnancies" even before *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), those hospitals did not hesitate to "treat[] patients whose health condition requires abortion as stabilizing care." J.A. 606, 611. For example:

- A woman presented to an Idaho emergency department at 15 weeks gestation with severe pre-eclampsia. J.A. 367. Her pre-eclampsia put her at risk of acute and long-term complications, including seizures and stroke. *Ibid.* Her condition was stabilized by terminating the pregnancy, which is "[t]he definitive medical treatment" for "pre-viable preeclampsia with severe features" because the fetus is not expected to survive and continuing the pregnancy threatens the patient's "future fertility and long-term health." J.A. 615-616.
- A woman presented to an Idaho emergency department at 19 weeks gestation with preterm premature rupture of membranes—that is, her amniotic sac had broken. J.A. 357. Had she not received medical care to terminate her

pregnancy, she would have been at risk of "catastrophic injuries such as septic emboli necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy." J.A. 599.

- A woman presented to an Idaho emergency department at 19 weeks gestation with placental abruption: her placenta had separated from the wall of the uterus. J.A. 360. Her condition was stabilized with an emergent dilation and evacuation, terminating the pregnancy. J.A. 361. Absent that care, she would have been at risk of kidney failure and hypoxic brain injury. J.A. 599.

The record includes many other recent examples. See J.A. 361-362, 368-369, 373-375. Because pregnancy termination is the necessary stabilizing care in such cases, EMTALA requires that covered hospitals offer and provide such treatment if the patient chooses to receive it. 42 U.S.C. 1395dd(b)(1)(A) and (2).

3. Consistent with that straightforward reading of the text, all the entities involved in enacting, enforcing, and complying with EMTALA—HHS, courts, providers, and Congress itself—have long recognized that, in some circumstances, pregnancy termination is necessary stabilizing treatment.

HHS. In enforcing EMTALA, HHS has long taken action in those rare cases where a hospital fails to stabilize an emergency medical condition in circumstances where the necessary care was termination of the pregnancy.[2] HHS has also made that understanding explicit

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[2] See Ctrs. for Medicare & Medicaid Servs., *Hospital Surveys with 2567 Statement of Deficiencies - 2023Q4* (*CMS Hospital Surveys*) (last modified Feb. 13, 2024), https://perma.cc/8UCY-DK7Y

in communications with the public. In 2008, for example, HHS proposed a regulation interpreting the federal statutes that prohibit requiring doctors to perform abortions or other procedures that violate their religious or moral beliefs. Many comments expressed concerns that the proposed regulation would be "inconsistent with [EMTALA's] requirement that institutions provide care in an emergency." 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008). HHS responded that EMTALA's stabilization obligation is imposed on "hospitals," not on "individual providers," and that an issue would arise only if "a hospital, as opposed to an individual, has an objection to performing *abortions that are necessary to stabilize the mother*, as that term has been interpreted in the context of EMTALA." *Id.* at 78,088 (emphasis added).

In readopting a similar rule in 2019, HHS reaffirmed its 2008 understanding of the relationship between conscience protections and EMTALA. See 84 Fed. Reg. 23,170, 23,183 (May 21, 2019). And in 2021, HHS issued guidance reiterating that "[s]tabilizing treatment" for "[e]mergency medical conditions involving pregnant patients" may include "dilation and curettage"—that is,

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(2010-2016 file) Row 16,963 (2012 violation for discharging pregnant patient who required pregnancy termination as stabilizing treatment); (2010-2016 file) Row 20,800 (similar violation in 2011); (2010-2016 file) Rows 3732, 8645, 25,877 (violations for failure to provide stabilizing treatment, including pregnancy termination, to women experiencing complications from ectopic pregnancy in 2012, 2013, and 2015); (2017-2023 file) Rows 25,709, 45,218 (similar violations in 2018 and 2021). The linked spreadsheets document deficiencies related to all conditions of participation in Medicare between 2010 and 2023; EMTALA stabilization violations (tags A2407 and C2407) account for roughly 700 of the entries. Pre-2010 data is not readily available.

termination of the pregnancy. Ctrs. for Medicare & Medicaid Servs. (CMS), *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* 4 (Sept. 17, 2021), https://perma.cc/V4Y9-VDHG.

As petitioners note (*e.g.*, Idaho Br. 13-14), HHS issued further guidance in 2022 to "restate" its interpretation of EMTALA "in light of new state laws prohibiting or restricting access to abortion." CMS, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* 2 (July 11, 2022), https://perma.cc/GT5D-Q9FN. But petitioners are wrong to assert (*e.g.*, Leg. Br. 2) that the understanding of EMTALA reflected in that guidance was "novel." The conflict between EMTALA and post-*Dobbs* state laws was new, but the interpretation of EMTALA reflected in the 2022 guidance is the same one HHS has articulated and enforced across at least four presidential administrations.[3]

Courts. Although the issue seldom arose, every court to consider the issue before *Dobbs* recognized that, in some circumstances, pregnancy termination is the required stabilizing treatment under EMTALA. For example, in *Ritten* v. *Lapeer Regional Medical Center*, 611 F. Supp. 2d 696 (E.D. Mich. 2009), the court recognized that EMTALA's anti-retaliation provision—which bars retaliation for refusing to transfer "an individual with an emergency medical condition that has not been stabilized," 42 U.S.C. 1395dd(i)—applied to a doctor who refused to transfer a patient who required pregnancy termination. *Ritten*, 611 F. Supp. 2d at 709, 713-

[3] The 2022 guidance has been enjoined within Texas and as to members of two organizational plaintiffs in separate litigation. See *Texas* v. *Becerra*, 89 F.4th 529, 533 (5th Cir. 2024).

718; see also, *e.g.*, *New York* v. *HHS*, 414 F. Supp. 3d 475, 537-539 (S.D.N.Y. 2019); *California* v. *United States*, No. 05-328, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008).[4]

Providers. The medical community has likewise long understood that EMTALA's stabilization requirement encompasses pregnancy termination where necessary to stabilize an emergency medical condition. The largest hospital system in Idaho has emphasized that the contrary suggestion "would stun the vast majority of medical providers." St. Luke's Amicus Br. 8 n.6. The physician declarations in the record likewise recognize that pregnancy termination is in some circumstances "required under EMTALA." J.A. 617; see, *e.g.*, J.A. 607, 612. And the comments on HHS's conscience rulemakings reflect the same understanding. See 84 Fed. Reg. at 23,183; 73 Fed. Reg. at 78,087.

Congress. In the prominent and carefully negotiated section of the Affordable Care Act addressing the Act's effect on laws dealing with abortion, Congress directed that the Act would not require insurance plans to cover abortion and prohibited the use of federal subsidies for certain abortions. 42 U.S.C. 18023(a) and (b); see John Cannan, *A Legislative History of the Affordable Care Act*, 105 Law Libr. J. 131, 157, 167-168 (2013). But

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[4] Idaho's quibbles (Br. 28) with these decisions lack merit. Idaho emphasizes that *California* and *New York* addressed HHS's conscience rules rather than direct applications of EMTALA. But we rely on those decisions not for their conclusions about the conscience statutes and rules, but instead for their holdings that—as HHS itself made explicit in the rulemakings, see pp. 16-18, *supra*—EMTALA requires pregnancy termination when necessary to stabilize an emergency medical condition. And although there was a factual dispute in *Ritten* about the required stabilizing care, the court deemed that disagreement "irrelevant." 611 F. Supp. 2d at 715-716.

Congress also emphasized that "[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as 'EMTALA')." 42 U.S.C. 18023(d). Congress's inclusion of that disclaimer in a section of the statute focused exclusively on abortion reaffirms that pregnancy termination can constitute required stabilizing care under EMTALA. See AHA Amicus Br. 20-23.

B. Section 18-622 Is Preempted When It Prohibits Stabilizing Treatment Required Under EMTALA

The district court correctly recognized that there are narrow but important circumstances where Section 18-622 conflicts with EMTALA: When a pregnant woman is suffering from an emergency medical condition that, absent termination of the pregnancy, threatens serious harm to her health—but not (absent further deterioration) to her life. In those circumstances, and only those circumstances, Section 18-622 is preempted.

1. EMTALA expressly preempts state laws that "directly conflict[]" with its requirements. 42 U.S.C. 1395dd(f). Under black-letter preemption principles, a conflict exists "where 'compliance with both state and federal law is impossible,' or where 'the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Oneok, Inc.* v. *Learjet, Inc.*, 575 U.S. 373, 377 (2015) (citation omitted). Both standards are satisfied here.

In some circumstances, Section 18-622 directly conflicts with EMTALA because it is impossible to comply with both laws. Section 18-622 criminalizes abortion care unless "necessary" to prevent the patient's "death." Idaho Code § 18-622(2)(a)(i). But as the district court

found, pregnant women arrive at emergency rooms suffering from dangerous conditions that do not yet threaten their lives, but where termination of the pregnancy is the only care that can prevent grave harms to their health. See pp. 7-8, *supra*. In such circumstances, EMTALA directs that the hospital "must provide" that treatment if the patient chooses to receive it, 42 U.S.C. 1395dd(b)(1)—but Section 18-622 makes that treatment a felony.

The district court likewise correctly concluded that by criminalizing stabilizing care in those circumstances —and by requiring suspension of the provider's license and a mandatory minimum of two years' imprisonment —Section 18-622 stands as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." J.A. 643 (citation omitted). These severe sanctions have a "deterrent effect," J.A. 644, and obstruct Congress's purpose of ensuring that all individuals "receive adequate emergency medical care," *Arrington* v. *Wong*, 237 F.3d 1066, 1074 (9th Cir. 2001) (citation omitted).

2. Petitioners at times appear to suggest (Leg. Br. 13-14, 29-30; Idaho Br. 31-32) that any care required under EMTALA is permitted by Section 18-622's necessary-to-prevent-death exception. But if that were true, the preliminary injunction would have no practical effect and petitioners would have had no basis for seeking extraordinary emergency relief from this Court. And by its plain terms, Section 18-622 prohibits care in circumstances where EMTALA requires it.

a. As relevant here, Section 18-622 permits termination of a pregnancy only in cases of molar or ectopic pregnancy, or when "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a). The

Idaho Supreme Court has construed the necessary-to-prevent-death exception as "subjective," "focusing on the particular physician's judgment" rather than "requir[ing] *objective* certainty." *Planned Parenthood Great Nw.* v. *Idaho*, 522 P.3d 1132, 1203 (2023). But a physician still must determine that pregnancy termination is "necessary" to prevent "death"—not merely to avoid grave harm to health. *Ibid.*

Although EMTALA's stabilizing-treatment requirement is limited to serious medical emergencies, it is broader than Idaho law in two critical respects. First, it requires stabilizing treatment when a patient is at risk of serious harm to her *health*, including serious impairment to bodily functions or dysfunction of a bodily organ, 42 U.S.C. 1395dd(e)(1)(A)—not only when the patient is at risk of *death*. Second, EMTALA requires stabilizing treatment when the requisite harm "could reasonably be expected to result" absent immediate medical attention, *ibid.*—not only when care is *necessary* to prevent harm.

Section 18-622's narrower language is not an accident. The Idaho Supreme Court has explained that other Idaho abortion laws include a "'medical emergency' exception" defined in terms "*substantially similar*" to "EMTALA." *Planned Parenthood*, 522 P.3d at 1207. Those laws would allow pregnancy termination not only when necessary to "avert [the pregnant woman's] death," but also when "delay will create serious risk of substantial and irreversible impairment of a major bodily function." Idaho Code § 18-8804. But Section 18-622 has now overridden those laws, and its omission of any similar language reflects the Legislature's deliberate "decision" to "focus on the life of the mother versus a health exception." Idaho Senate State Affairs

Comm., *Minutes* 3 (Mar. 30, 2023), https://perma.cc/QC9M-LBQV (statement of Sen. Lakey). Petitioners cannot plausibly maintain that the purposefully narrower scope of Section 18-622 has no practical effect.

b. Petitioners do not deny that Section 18-622's plain language is meaningfully narrower than EMTALA. They assert, however, that many of the pregnancy complications identified by the government's physician declarants could ultimately result in "life-threatening situations." Leg. Br. 13 (brackets and citation omitted); Idaho Br. 31. But Section 18-622 demands more—it asks whether termination is *necessary* to prevent the woman's death, not whether the condition is potentially "life-threatening." Even more fundamentally, EMTALA mandates intervention long before that point—when the patient's *health* is threatened. See pp. 21-22, *supra*. And it "is simply not the case" that "whenever abortion is medically necessary, it is necessary to prevent the mother's death." J.A. 605-606.

As the government's experts explained, many of the most common pregnancy complications do not threaten the pregnant woman's life when she arrives at the emergency room. For example, a woman suffering from preterm premature rupture of membranes before infection sets in is likely not at risk of death "at the point of diagnosis." J.A. 594. Yet "immediate treatment through termination of pregnancy may be necessary because delaying treatment would allow the condition to progress, thereby threatening other bodily organs and functions." *Ibid.* Similarly, "[t]he definitive medical treatment for pre-viable preeclampsia with severe features is termination of pregnancy"—not just "continued observation"—because the condition "places a patient at risk for both acute and long-term complications." J.A. 615. But

"[t]he medical rationale * * * is not always to prevent death; in the majority of cases it is to avoid further deterioration, physical harm, and threat to future fertility and long-term health." J.A. 615-616.

Of course, if care is delayed long enough, pregnancy termination may sometimes become necessary to save the woman's life because her condition has deteriorated. But waiting until that point violates EMTALA, which requires stabilizing treatment to *avoid* "material deterioration of the condition." 42 U.S.C. 1395dd(e)(3). And the delay can have devastating consequences. If a doctor acting on pain of felony prosecution must wait to provide treatment until she can deem it necessary to prevent death, the patient "may have to live the remainder of her life with significant disabilities and chronic medical conditions as a result of her pregnancy complication." J.A. 621. And "[f]or rural patients in particular, delaying medical care until [doctors] can say an abortion is necessary to prevent death" is especially "dangerous"; once the patient's condition deteriorates, there is no guarantee a rural hospital will be able to treat it. J.A. 612.

Even brief experience has confirmed that Section 18-622 has damaging effects in the emergency circumstances where EMTALA would require pregnancy termination. During the short period the Ninth Circuit panel's stay was in effect, a woman had to be flown to Utah for treatment "after her water broke about five months early," creating an urgent risk of infection, "sepsis," and "organ failure"—but which Idaho doctors facing potential felony prosecution could not say met Section 18-622's necessary-to-prevent-death threshold. Kelcie Moseley-Morris, *Most Americans want health exceptions in abortion bans*, Idaho Capital Sun (Nov. 7,

2023), https://perma.cc/MDR8-GE6X. And after this Court stayed the preliminary injunction, Idaho doctors reported that they would have to "transfer more patients out of state for abortion care" rather than wait for the situation to become "life-threatening." Kelcie Moseley-Morris, *U.S. Supreme Court agrees to hear Idaho case on emergency room abortions*, Idaho Capital Sun (Jan. 5, 2024), https://perma.cc/W6F2-CQ8U.

Even when such out-of-state transfers are possible, they "put patients at risk due to significant delays in care." St. Luke's Amicus Br. 15. And "if those delays create a situation where the patient is no longer stable enough" to be transferred, Idaho physicians must "wait until termination is necessary to prevent the patient's death, knowing that the wait could have severe health consequences." *Ibid.*

The Legislature's assertion (Br. 28) that "nothing in the statute requires 'delayed' care" is cold comfort. Section 18-622 threatens physicians with criminal prosecution, mandatory prison terms, and loss of their medical licenses for terminating a pregnancy unless such care is necessary to prevent the woman's death. Idaho law thus puts providers in an impossible position: They can terminate a pregnancy to prevent serious harm to a patient's health and risk violating Section 18-622, or delay care until the statutory standard is clearly met, while the patient continues to deteriorate. Delayed care and out-of-state transfers, with all the dangers those entail, are the inevitable real-world consequence. See St. Luke's Amicus Br. 10, 12-17.

3. Although the gap between Section 18-622 and EMTALA can have life-altering consequences for pregnant women, it bears emphasis that EMTALA requires pregnancy termination only in rare circumstances. The

Act applies only when a pregnant woman has an emergency condition that places her health in "serious jeopardy" or threatens "serious impairment to bodily functions" or "serious dysfunction" of a bodily organ or part. 42 U.S.C. 1395dd(e)(1)(A). And pregnancy termination is the required stabilizing care only if no other treatment will stabilize the condition and termination is necessary to "assure, within reasonable medical probability," that the condition will not materially deteriorate. 42 U.S.C. 1395dd(e)(3)(A).[5]

That means, for example, that if complications occur later in pregnancy and the fetus can be delivered safely, there is no conflict between EMTALA and Idaho law—which explains why the issue apparently never arose under pre-*Dobbs* laws "prohibit[ing] abortions after viability." Idaho Br. 38-39. Instead, as the record shows, situations where EMTALA and Section 18-622 conflict ordinarily occur before viability. And as the Legislature's own declarants recognize, in many such cases the fetus will not ultimately survive "with or without surgery" because the pregnancy is no longer healthy—for instance, after placental abruption or preterm rupture of the membranes. J.A. 573; see J.A. 571-574. Waiting for the woman's condition to further deteriorate before terminating the pregnancy thus puts the patient's health at grave risk with little additional likelihood of fetal survival. Yet that is what Idaho law would require

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[5] Idaho badly errs in asserting (Br. 30) that construing EMTALA according to its terms would turn "emergency rooms into federal abortion enclaves" by allowing pregnancy termination for "mental health" concerns. Idaho neither identifies a single case where an emergency-room physician terminated a pregnancy to stabilize a mental-health condition, nor cites any clinical standard identifying termination as necessary stabilizing care in such circumstances.

were it not preempted by EMTALA in these rare but tragic circumstances.

C. Petitioners' Contrary Arguments Lack Merit

Petitioners' position has shifted dramatically during this litigation. In the district court, they acknowledged the existence of "circumstances when stabilizing treatment necessitated by EMTALA includes an abortion." D. Ct. Doc. 66, at 13 (Aug. 16, 2022) (Idaho); see D. Ct. Doc. 65, at 9 (Aug. 16, 2022) (Legislature). Petitioners now take the opposite view, but they make little effort to ground their position in EMTALA's operative text. Indeed, it is still not entirely clear what petitioners think EMTALA's stabilizing-treatment requirement means. They sometimes assert that EMTALA never requires *any* specific stabilizing treatment. At other times, they seem to acknowledge that EMTALA can require specific treatments, but only if those treatments are consistent with state law. And in still other places, petitioners fall back to an abortion-specific interpretation, insisting EMTALA implicitly exempts pregnancy termination. All of those arguments contradict EMTALA's text and would upend long-settled understandings. And petitioners' various appeals to extra-textual considerations provide no justification for overriding the statute's natural meaning.

1. EMTALA mandates stabilizing care, not merely equal treatment

Petitioners' most radical argument is that "EMTALA does not mandate any specific services or standard of care." Idaho Br. 32; see, *e.g.*, Leg. Br. 1-2. On that view, which the Ninth Circuit stay panel and the Fifth Circuit endorsed, EMTALA simply requires "that indigent and paying clients be treated equally," but "does not give

patients a federal right to receive" any particular care. Idaho Br. 17, 31-32; see J.A. 698-699; *Texas* v. *Becerra*, 89 F.4th 529, 542 (5th Cir. 2024). That flatly contradicts EMTALA's text and would overturn a settled understanding that has prevailed for decades—not just in the context of pregnancy termination, but in all of EMTALA's applications.

a. EMTALA unambiguously requires more than mere parity of treatment. Congress directed covered hospitals to provide essential care to "any individual" determined to have an emergency medical condition, not just those who are indigent or lacking insurance. 42 U.S.C. 13955dd(a). Congress did not define the required care in comparative terms; instead, it mandated "such treatment as may be required to *stabilize* the [individual's] medical condition." 42 U.S.C. 1395dd(b)(1) (emphasis added). And Congress left no doubt that "to stabilize" is a substantive federal standard, defining that term to mean "such medical treatment * * * as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition" is likely to occur. 42 U.S.C. 1395dd(e)(3)(A).

Construing the law to prohibit only discrimination against indigent patients would "directly conflict[] with the plain language of EMTALA" by permitting covered hospitals to provide "treatment that would allow [an individual's] condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals." *In re Baby "K"*, 16 F.3d 590, 595-596 (4th Cir.) (*Baby K*), cert. denied, 513 U.S. 825 (1994). This Court has already rejected a similar attempt to transform EMTALA's stabilization requirement into a nondiscrimination rule. In *Roberts* v. *Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per

curiam), the court of appeals had held that a hospital violates EMTALA only if its "inappropriate stabilization resulted from an improper motive such as one involving the indigency, race, or sex of the patient." *Id.* at 252. This Court unanimously and emphatically rejected that approach, "[f]inding no support for such a requirement in the text of the statute." *Id.* at 250. So too here.

b. Like the court of appeals in *Roberts*, petitioners make little effort to ground their nondiscrimination interpretation in EMTALA's operative text. Instead, they invoke a separate provision of the original 1965 Medicare Act specifying that nothing in the Act "shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine." 42 U.S.C. 1395; see Idaho Br. 11; Leg. Br. 18, 21, 25. But EMTALA's stabilization requirement was enacted by Congress itself, not imposed by a "Federal officer or employee." Nor can petitioners plausibly maintain that Section 1395 prohibits interpreting EMTALA to require a hospital to provide particular care in particular cases—after all, petitioners' interpretation requires a hospital to provide the same care it would provide to other patients. And even if there were some tension between the two provisions, EMTALA would control because it is later-enacted and far more "specific." *RadLAX Gateway Hotel, LLC* v. *Amalgamated Bank*, 566 U.S. 639, 645 (2012).

c. Departing from the text altogether, petitioners emphasize (*e.g.*, Idaho Br. 7, 9, 17, 36-37) that Congress enacted EMTALA to end the practice of patient dumping. But Congress's specific concern with patient dumping reflected its commitment to a broader principle: that "every patient who has a bonafide emergency"

should receive stabilizing care. 131 Cong. Rec. at 28,569 (Sen. Kennedy); see, *e.g.*, *ibid.* (Sen. Dole). The statute that Congress enacted mandates that care in plain terms: EMTALA requires stabilizing treatment, not merely equal treatment. See pp. 28-29, *supra*. This Court presumes that Congress "says in a statute what it means and means in a statute what it says." *Connecticut Nat'l Bank*, 503 U.S. at 253-254.

d. Until the Fifth Circuit's decision in *Texas* v. *Becerra*, *supra*, no court of appeals had adopted the atextual reading of EMTALA that petitioners urge. Instead, courts have long recognized that "once an individual has been diagnosed as presenting an emergency medical condition," EMTALA requires the hospital to "provide that treatment necessary to prevent the material deterioration of the individual's condition." *Baby K*, 16 F.3d at 594; see, *e.g.*, *Moses* v. *Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 582 (6th Cir. 2009), cert. denied, 561 U.S. 1038 (2010); *Thomas* v. *Christ Hosp. & Med. Ctr.*, 328 F.3d 890, 893-896 (7th Cir. 2003). So, for example, if a patient's hypertension triggers EMTALA, the hospital must provide "treatment that medical experts agree would prevent the threatening and severe consequences of [the patient's] hypertension while she was in transit." *Burditt* v. *HHS*, 934 F.2d 1362, 1368-1369 (5th Cir. 1991).

By the same token, courts of appeals—including in decisions Idaho invokes (Br. 26-27)—have consistently refused to read EMTALA as a mere nondiscrimination rule. As those courts have explained, although EMTALA's "legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and without insurance." *Gatewood* v. *Washington*

Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991). "Rather, the Act's plain language unambiguously extends its protections to 'any individual' who seeks emergency room assistance." *Ibid.* (citation and emphasis omitted); see *Hardy* v. *New York City Health & Hosps. Corp.*, 164 F.3d 789, 792-793 (2d Cir. 1999); *Correa* v. *Hospital S.F.*, 69 F.3d 1184, 1194 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1259 n.3 (9th Cir. 1995); *Baby K*, 16 F.3d at 595-596.[6]

Petitioners cite decisions stating that EMTALA does not create "a general federal cause of action for medical malpractice" under "a national standard of care." Idaho Br. 26-27 (citation omitted); see Leg. Br. 27 & n.5 (same). But those decisions do not hold that EMTALA prohibits only discrimination against the uninsured. Instead, they simply recognize that liability under EMTALA "is determined independently of whether any deficiencies in the screening or treatment provided by the hospital may be actionable as negligence or malpractice." *Torretti* v. *Main Line Hosps., Inc.*, 580 F.3d 168, 173-174 (3d Cir.), amended, 586 F.3d 1011 (2009). A state-law malpractice action asks whether any aspect of the provider's treatment breached a duty of care as defined by state law. By contrast, EMTALA asks a more focused

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[6] Some courts of appeals have stated that EMTALA's *screening* provision requires only uniform treatment among the indigent and insured. See, *e.g.*, *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996). But unlike the stabilization requirement, the screening provision does not impose an obligation to provide medical care to achieve a specific objective. See 42 U.S.C. 1395dd(a). And in *Roberts*, this Court recognized that EMTALA's screening and stabilization obligations need not be construed in tandem—and squarely rejected the view that the stabilization obligation requires only equal treatment. 525 U.S. at 252-253.

question: Whether a provider satisfied a specific statutory obligation to "stabilize" an "emergency medical condition." 42 U.S.C. 1395dd(b)(1)(A).

Consider, for example, a patient who comes to a hospital complaining of abdominal pain. A doctor performs a screening examination, diagnoses appendicitis, and provides stabilizing treatment (appendectomy) to alleviate the acute symptoms, resolving the emergency medical condition. But the doctor fails to diagnose the patient as having metastatic appendiceal cancer despite obvious markers visible during the surgery. The hospital satisfied its EMTALA obligation, but the patient may have a claim for malpractice.

EMTALA, accordingly, is "not a substitute for state law malpractice actions." *Power* v. *Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994). It does not "guarantee proper diagnosis" or "provide a federal remedy for misdiagnosis or medical negligence." *Hardy*, 164 F.3d at 792 (citation omitted). But it does establish a baseline duty to provide "stabilizing treatment for a patient who arrives with an emergency condition," *Bryan* v. *Rectors & Visitors*, 95 F.3d 349, 351 (4th Cir. 1996), by asking whether a hospital "provid[ed] an adequate first response to a medical crisis," *Cherukuri* v. *Shalala*, 175 F.3d 446, 451 (6th Cir. 1999) (citation omitted).[7]

e. Of course, EMTALA does not itself set forth the specific treatments necessary to stabilize particular

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

emergency medical conditions. Instead, it defines stabilizing treatment in terms of what is "necessary to assure, within *reasonable medical probability*, that no material deterioration of the condition is likely." 42 U.S.C. 1395dd(e)(3)(A) (emphasis added). HHS thus instructs that EMTALA compliance depends on "[a]ccepted standards of medical practice," "[e]vidence-based clinical standards," and "[s]ound clinical judgment." CMS, *Quality Improvement Organization Manual*, Ch. 9, at 43 (Rev. 24, Issued Feb. 12, 2016), https://perma.cc/WV4G-W6EV. To that end, "physician reviewers" assessing EMTALA compliance "evaluate the care, or lack of care, provided in accordance with national standards of practice." CMS, *EMTALA and the Born-Alive Infant Protection Act* (June 27, 2019), https://perma.cc/AL4B-T9CX; see, *e.g.*, CMS, *EMTALA Physician Review Worksheet* (Rev. 134, Issued Feb. 20, 2015), https://perma.cc/434U-7TUE.

HHS's decades-long enforcement of EMTALA underscores the novelty of petitioners' position—and the destabilizing consequences that would follow if this Court adopted it. HHS has long instructed entities involved in EMTALA enforcement that EMTALA's stabilization obligation is satisfied when "the treating physician * * * in the emergency department/hospital has determined, *within reasonable clinical confidence, that the emergency medical condition has been resolved.*" CMS, *State Operations Manual*, App. V, at 50 (Rev. 191, July 19, 2019), https://perma.cc/23A7-KYGQ (emphasis added).

HHS has also long recognized that EMTALA often requires a particular treatment to stabilize an emergency medical condition because only one treatment is consistent with accepted clinical standards. Such

conditions may include anaphylaxis (requiring epinephrine); hemorrhagic shock (requiring blood transfusion); cardiac arrest (requiring defibrillation); bacterial infections and meningitis (requiring antibiotics); blood clots (requiring anticoagulants); hyperkalemia with kidney failure (requiring dialysis); diabetic ketoacidosis (requiring insulin); opioid overdose (requiring antagonist); infected obstructing kidney stones (requiring percutaneous nephrostomy); collapsed lung (requiring chest tube); and acute respiratory failure (requiring mechanical ventilation).[8] Just as a covered hospital would violate EMTALA if it failed to provide one of those specific treatments when a patient presented with an emergency condition requiring such care, a hospital violates EMTALA if it fails to offer pregnancy termination in a situation where that care is the only medically appropriate stabilizing treatment.

As the foregoing discussion makes clear, petitioners attack a straw man when they assert that our view would mean that EMTALA "requires whatever stabilizing treatment a physician deems necessary," even if that judgment is idiosyncratic or inconsistent with accepted medical standards. Leg. Br. 26; see Idaho Br. 25-26. The necessary stabilizing treatment under EMTALA is determined by the stabilization obligation set forth in the statutory text and the evidence-based clinical standards that determine what that obligation requires in a particular case.[9]

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[8] See generally *CMS Hospital Surveys* (documenting these and other EMTALA violations from 2010-2023).

[9] There is thus no basis for Idaho's inflammatory assertion (Br. 30) that HHS's longstanding interpretation of EMTALA would allow doctors to "lobotomi[ze]" children or "euthan[ize]" mental-health patients. Unlike pregnancy termination, which is the only

2. The stabilizing treatment EMTALA requires is not limited by state law

Petitioners assert that even if EMTALA sometimes requires particular stabilizing treatments, it does not require treatments that violate state law. But again, that interpretation has no foundation in EMTALA's text. Indeed, it would stand EMTALA's preemption provision on its head.

a. Nothing in EMTALA's operative text suggests that state law limits EMTALA's mandate to provide stabilizing treatment. Idaho's framing in seeking a stay is telling: It asserted that "EMTALA's directive that hospitals provide 'such treatment as may be required to stabilize the medical condition' is best interpreted to mean such treatment *among those treatments that are authorized under both state and federal law*." 23A470 Appl. 17 (citation omitted). Of course, Congress did not include the italicized words, and this Court "ordinarily resist[s] reading words or elements into a statute that do not appear on its face." *Dean* v. *United States*, 556 U.S. 568, 572 (2009) (citation omitted).

Idaho now seeks to reframe the point, suggesting that construing EMTALA to preempt conflicting state law would require interpreting the statute to mandate "'treatment as may be required to stabilize [an emergency] medical condition [*regardless of whether such treatment is authorized under state law*].'" Br. 28 (citation omitted). But read in light of the Supremacy Clause, that is precisely what EMTALA says. It requires participating hospitals to provide necessary

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medical treatment that can stabilize certain pregnancy complications, the actions petitioners posit are not the evidence-based standard of care necessary to stabilize *any* emergency medical condition.

stabilizing treatment; if state law prohibits that care, it is state law that must give way—not EMTALA.

Grasping for a textual hook, Idaho asserts (Br. 25-26) that care prohibited by state law is not "within the staff and facilities available at the hospital," 42 U.S.C. 1395dd(b)(1)(A). But by its plain terms, the reference to "available" facilities and staff refers to physical and personnel constraints. See *State Operations Manual*, App. V, at 48 ("physical space, equipment, supplies, and specialized services," as well as "personnel"). It cannot plausibly be read as a cryptic incorporation of state law. To the contrary, when Congress meant to incorporate state law in EMTALA, it said so expressly. See 42 U.S.C. 1395dd(d)(2)(A) and (B) (authorizing damages available "under the law of the State in which the hospital is located").

b. EMTALA's preemption provision further refutes petitioners' reading by expressly preempting any state law "requirement" that "directly conflicts" with EMTALA's "requirement[s]." 42 U.S.C. 1395dd(f). If state law prohibits the only care that would assure, within reasonable medical probability, that no material deterioration of the individual's emergency medical condition is likely to result—that is, the care EMTALA "require[s]"—that state law is expressly preempted. Petitioners' reading inverts Congress's directive about the relationship between state and federal law. Indeed, if petitioners' reading were correct, it is difficult to see what work EMTALA's express preemption provision would do.

Petitioners' efforts to cabin EMTALA's preemption provision are meritless. They emphasize (Idaho Br. 11; Leg. Br. 22-23) that EMTALA does not preempt state law unless the law "directly" conflicts with the Act's

requirements. But that limitation simply ensures that EMTALA does "not preempt stricter state laws." H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 4 (1985); see, *e.g.*, *Baker* v. *Adventist Health, Inc.*, 260 F.3d 987, 993 (9th Cir. 2001) (Section 1395dd(f) preserves additional "state remedies"). In contrast, if state law does directly conflict with EMTALA—here, by prohibiting the very care EMTALA requires—Section 1395dd(f) makes clear that EMTALA controls.

The Legislature also suggests that EMTALA's preemptive scope is narrowed by the word "directly," a purportedly "rare modifier." Br. 22-23 (citation omitted). But express preemption provisions often refer to "direct" conflicts. See, *e.g.*, 7 U.S.C. 2156; 15 U.S.C. 1225; 16 U.S.C. 544*l*(e)(5), 3507; 43 U.S.C. 1600g. And that is unsurprising because this Court has repeatedly explained that federal law preempts "direct[ly]" conflicting state law. See, *e.g.*, *Southland Corp.* v. *Keating*, 465 U.S. 1, 10 (1984); *Philko Aviation, Inc.* v. *Shacket*, 462 U.S. 406, 410 (1983).

c. Petitioners' contention that state law limits EMTALA's stabilization requirement is also inconsistent with the statute's history. "EMTALA was enacted to fill a lacuna in traditional state tort law by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all." *Hardy*, 164 F.3d at 792-793. In requiring hospitals to offer stabilizing treatment to any individual who presents with an emergency condition, EMTALA thus preempted the common law rule that still governed in many States. There is no reason to think that Congress meant for state law to limit EMTALA's stabilization obligation when the very purpose of that obligation was to displace

the prior state-law regime with a minimum national requirement for emergency care.

d. Until recently, no court had adopted petitioners' view that state law can exempt providers from offering care otherwise required by EMTALA. The Fourth Circuit expressly rejected that argument in *Baby K*, concluding that "to the extent [state law] exempts physicians from providing" stabilizing care, it is preempted by EMTALA. 16 F.3d at 597.

Idaho's attempt (Br. 33-34) to re-imagine *Baby K* is unpersuasive. There, a hospital sought to stop providing respiratory support to an anencephalic infant. 16 F.3d at 592. The hospital invoked Virginia law, which authorized doctors to deny "medical treatment" they "determine[d] to be medically or ethically inappropriate." *Id.* at 597 (citation omitted). The hospital argued that because "its physicians object to providing respiratory support to anencephalics, it has no physicians available to provide respiratory treatment for Baby K and, therefore, is not required by EMTALA to provide such treatment." *Ibid.* The Fourth Circuit disagreed, explaining that "to the extent that [Virginia law] exempts treating physicians in participating hospitals from providing care they consider medically or ethically inappropriate, it is preempted." *Ibid.* Idaho thus misses the mark in emphasizing (Br. 33) that "state law allowed the stabilizing care requested." The relevant point is that Virginia law was preempted by EMTALA because it did *not* allow doctors to be required to render the necessary stabilizing care. *Baby K*, 16 F.3d at 592.

e. Finally, petitioners' inversion of EMTALA's preemption provision would upend settled understandings. HHS has long instructed regulated entities that EMTALA overrides state law where it conflicts with the

obligations imposed by EMTALA. For instance, the State Operations Manual provides that "a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation." App. V, at 40. Similarly, the Manual instructs that "a woman in labor may be transferred only if" the transfer satisfies EMTALA; "[a] hospital cannot cite State law or practice as the basis for transfer." *Id.* at 61. On petitioners' view, such state laws—and any state law banning or restricting a necessary medical treatment—would override EMTALA's stabilization requirement. That would allow EMTALA's meaning to vary from state to state, thwarting Congress's promise of essential emergency care to all Americans.

3. EMTALA does not implicitly exclude pregnancy termination from necessary stabilizing care

Petitioners offer yet another gloss on EMTALA, arguing that even if covered hospitals must provide essential emergency care regardless of state law, the required care never includes termination of a pregnancy. Idaho Br. 32-35; Leg. Br. 28-35. That argument, too, is premised on a misreading of EMTALA's text. And if accepted, it would mean that EMTALA would pose no obstacle if a State prohibited pregnancy termination even when necessary to save the pregnant woman's life.

a. Petitioners assert (Idaho Br. 13, 22-23; Leg. Br. 2, 25, 55) that because EMTALA does not expressly reference pregnancy termination, it cannot require such care. But again, EMTALA mandates a general care objective: stabilization. It does not purport to specify the particular treatments necessary to achieve that objective for the wide range of emergency medical conditions it covers. But if a patient presents with an emergency

condition and only one treatment would stabilize the patient, that treatment is required.

A hospital that failed to provide a chest tube for a collapsed lung or defibrillation for cardiac arrest, for example, could not defend itself by asserting that EMTALA does not mention those specific treatments. See p. 34, *supra*. EMTALA treats pregnancy termination the same way: It is required if, and only if, such care constitutes the requisite stabilizing treatment to assure within reasonable medical probability that no material deterioration of the condition is likely to occur. 42 U.S.C. 1395dd(e)(3).

Petitioners emphasize (Idaho Br. 32-33; Leg. Br. 6, 25) that EMTALA mentions a specific form of stabilizing treatment in one circumstance: when a pregnant woman is in labor and "having contractions." 42 U.S.C. 1395dd(e)(1)(B); see 42 U.S.C. 1395dd(e)(3)(A). But EMTALA singles out that scenario to expand the definition of "emergency medical condition" to include labor. In identifying "deliver[y]" as "stabiliz[ation]" in that one instance, Congress did not override EMTALA's general stabilization obligation—or exclude any other necessary stabilizing treatment.

Statutory context reinforces that conclusion. When Congress intends to create special rules governing abortion or excluding abortion care from otherwise-applicable rules, it does so explicitly. See, *e.g.*, 10 U.S.C. 1093; 20 U.S.C. 1688; 22 U.S.C. 5453(b), 7704(e)(4); 25 U.S.C. 1676(a); 42 U.S.C. 238n, 280h-5(a)(3)(C), 300a-6, 300a-7, 300a-8, 300z-10(a), 1397ee(c)(7)(A), 2996f(b)(8), 12584a(a)(9); pp. 19-20, *supra*; p. 45, *infra*. But EMTALA does not include such language, underscoring that Congress did not intend to exclude such care from EMTALA's mandate.

b. Petitioners argue (Idaho Br. 17, 32-34; Leg. Br. 25-26, 28-29) that EMTALA's references to an "unborn child" necessarily exclude pregnancy termination from the mandate to provide necessary stabilizing treatment. That is incorrect.

All of EMTALA's duties—screening, stabilization, and transfer—run to the "individual" seeking care. Subsection (a) provides that a hospital's screening obligation arises when an "individual" "comes to the emergency department" and a request for examination or treatment "is made on the individual's behalf." 42 U.S.C. 1395dd(a). Subsection (b) provides that a hospital's stabilization obligation arises if it determines that "the individual has an emergency medical condition." 42 U.S.C. 1395dd(b)(1). The "individual" must be informed of risks and benefits and can give "informed consent to refuse such examination and treatment." 42 U.S.C. 1395dd(b)(2). And subsection (c) restricts transfer until the "individual" is stabilized. 42 U.S.C. 1395dd(c)(1).

When a pregnant woman presents with an emergency medical condition, she is the "individual" to whom those obligations run. The provision of EMTALA addressing pregnant patients distinguishes between "the individual" (denoting the "pregnant woman") and "her unborn child." 42 U.S.C. 1395dd(e)(1)(A)(i); see 1 U.S.C. 8(a) (defining "individual" to "include every infant member of the species homo sapiens who is born alive at any stage of development," but not a fetus). Accordingly, when the treatment required to stabilize a pregnant woman's emergency medical condition is terminating the pregnancy, EMTALA requires the hospital to offer that treatment and allow her to make an informed decision about whether to proceed.

EMTALA's four references to an "unborn child" are consistent with that conclusion. Three of them direct hospitals to considers risks to an "unborn child" in determining whether a woman in labor may be permissibly transferred before delivery. 42 U.S.C. 1395dd(c)(1)(A)(ii), (2)(A), and (e)(1)(B)(ii). But those provisions do not displace the hospital's obligation to provide stabilizing treatment to a pregnant woman experiencing emergency complications whose continued pregnancy poses a serious threat to her life or health.

Petitioners likewise misapprehend the reference to an "unborn child" in Section 1395dd(e)(1)(A)(i), which defines an "emergency medical condition." As originally enacted, that definition did not specify whether a hospital owed any obligation to offer stabilizing treatment to a pregnant woman, not in labor, who came to an emergency room with a medical condition that jeopardized her unborn child's health, but not her own. See 42 U.S.C. 1395dd(e)(1)(A) (1988).

In 1989, Congress addressed that situation by expanding the definition of when a pregnant woman has an "emergency medical condition" to include conditions that threaten the health of her "unborn child." Pub. L. No. 101-239, § 6211(h), 103 Stat. 2248-2249; 42 U.S.C. 1395dd(e)(1)(A)(i); see H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 838 (1989). Accordingly, when a pregnant woman presents with an emergency condition that threatens her unborn child's health, the hospital owes her the same screening, stabilization, and transfer obligations that it owes any other patient with an emergency medical condition.

That salutary expansion of EMTALA did not alter the statute's requirements in the distinct scenario at issue here: When a pregnant patient presents with an

emergency condition that *does* threaten her health, and when pregnancy termination is the only treatment that will save her life or prevent serious harm. Such a woman still qualifies as an individual with an emergency medical condition, and pregnancy termination still qualifies as the care required to stabilize that condition. EMTALA thus unambiguously requires the hospital to offer that care. 42 U.S.C. 1395dd(b)(1)(A).

In many of those tragic situations, moreover, the pregnancy complication itself means the fetus will not survive even absent immediate termination of the pregnancy. See pp. 26-27, *supra*. In such circumstances, EMTALA cannot possibly impose a "dual stabilization requirement" extending to both the pregnant patient and the fetus, Leg. Br. 26, because there is no treatment that could "assure, within reasonable medical probability, that no material deterioration" of the fetus's condition is likely to occur. 42 U.S.C. 1395dd(e)(3).

To the extent in some circumstances forgoing the treatment necessary to avoid serious risks to the pregnant woman's health might allow her unborn child to survive, EMTALA makes clear that it is for the pregnant woman, not state law, to decide how to proceed. If the pregnant woman has an emergency medical condition, she must be offered the required stabilizing treatment and informed of the risks and benefits. 42 U.S.C. 1395dd(b)(2). Then "the individual (or a person acting on the individual's behalf)" must decide whether to consent to or refuse the treatment. *Ibid.* EMTALA thus establishes that it is the "individual"—that is, the pregnant woman—who must weigh the risks and decide whether to continue a dangerous pregnancy that is seriously jeopardizing her life or health.

c. It is worth underscoring the implications of petitioners' position. Section 18-622 does not prohibit pregnancy termination when that care is necessary to prevent a pregnant woman's death, and petitioners have strained to suggest (incorrectly) that the law's necessary-to-prevent-death exception is sufficient to address the sorts of grave medical emergencies reflected in the record in this case. But on petitioners' reading of EMTALA, nothing turns on that: Idaho or any other State could criminalize pregnancy termination under any or all circumstances, and EMTALA would never require that care. A State could ban termination of ectopic pregnancies. It could allow only a narrow affirmative defense for cases where it is objectively certain that the pregnant woman would otherwise die. Or a State could categorically prohibit abortion, even when necessary to save the woman's life. Under any of petitioners' various interpretations, EMTALA would not preempt those laws in any of their applications. That means a pregnant woman could arrive at a hospital urgently needing essential care and, instead of offering "such treatment as may be required to stabilize the medical condition," 42 U.S.C. 1395dd(b)(1)(A), the hospital would have to let her die. EMTALA's stabilization mandate cannot be such an empty promise.

4. Petitioners provide no reason to depart from the statutory text

Finally, petitioners invoke a variety of sources outside EMTALA to justify departing from the plain text of both the Act's stabilization requirement and its preemption provision. Those efforts are unpersuasive.

a. Petitioners first cite (Idaho Br. 34-35; Leg. Br. 31-35) various appropriations riders restricting federal funding for certain abortion care and provisions

targeting discrimination or coercion in the abortion context. But none of the cited provisions references—let alone purports to limit—EMTALA's stabilization obligation. To the extent federal funds cannot be used to pay for certain care required under EMTALA, that is no reason to except that care from EMTALA's stabilization mandate; much of the care EMTALA requires is not subsidized by federal funds in any event. And insofar as some provisions of federal law "disapprov[e]" (Leg. Br. 34) non-health-related abortion care, petitioners identify no statutory provision suggesting disapproval of medically necessary pregnancy termination to avoid grave harm to a pregnant woman's health.[10]

b. Petitioners assert that construing EMTALA to preempt conflicting state law would "exceed Congress's spending power." Leg. Br. 48; see Idaho Br. 20-21. But EMTALA reflects Congress's "broad power under the Spending Clause" to "set the terms on which it disburses federal funds." *Cummings* v. *Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 216 (2022); see 42 U.S.C. 1395cc(a)(1)(I)(i).

"[H]ealthcare facilities that wish to participate in Medicare and Medicaid have always been obligated to satisfy a host of conditions that address the safe and effective provision of healthcare." *Biden* v. *Missouri*, 595 U.S. 87, 94 (2022) (per curiam). And valid Spending Clause legislation is federal "Law[]" entitled to full preemptive force under the Supremacy Clause. U.S. Const. Art. VI, Cl. 2. This Court has thus consistently applied ordinary preemption principles to spending legislation even where, as here, the State is not the

[10] The Legislature also invokes (Br. 32) the federal ban on "partial-birth abortion," but there is no emergency medical condition that can only be stabilized by the procedure that law prohibits.

recipient of federal funds. See, *e.g.*, *Coventry Health Care of Mo., Inc.* v. *Nevils*, 581 U.S. 87, 95-99 (2017); *Bennett* v. *Arkansas*, 485 U.S. 395, 396 (1988) (per curiam); *Lawrence County* v. *Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 257-258 (1985); *Philpott* v. *Essex County Welfare Bd.*, 409 U.S. 413, 417 (1973); *Townsend* v. *Swank*, 404 U.S. 282, 285 (1971). A contrary ruling would undermine not only EMTALA, but all of the Medicare Act's preemption provisions, see 42 U.S.C. 1395w-25(a)(2)(E)(iv), 1395w-26(b)(3), 1395w-104(e)(5), 1395w-112(g)—as well as the preemptive effect of other Spending Clause legislation.

In support of petitioners' novel assertion that Spending Clause legislation lacks preemptive force, the Legislature contends that such a law is "'in the nature of a contract,'" and thus "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." Br. 49-50 (citation omitted). But Congress is not commanding Idaho to do anything; the funding recipients are hospitals, not the State. More fundamentally, the contract-law analogy is just that: an analogy. Conceptually, it helps answer questions about "the scope of conduct for which funding recipients may be held liable" and "the scope of available remedies." *Cummings*, 596 U.S. at 219 (citations omitted). But that analogy provides no reason to deny spending legislation the effect required by the Supremacy Clause.

The State appears to suggest (Br. 20-21) that spending legislation cannot preempt contrary state law because a funding recipient could comply with both laws by declining federal funds. But if a State sought to bar private hospitals from participating in Medicare by prohibiting them from complying with the Act's conditions,

that would plainly pose an "obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Oneok*, 575 U.S. at 377 (citation omitted). And even if States could prevent hospitals from participating in Medicare altogether, they still could not do what Idaho seeks to do here: Allow hospitals to participate in a federal program but bar them from complying with the conditions set by Congress.

For similar reasons, the Legislature errs (Br. 53-56) in invoking the Tenth Amendment. There is no Tenth Amendment violation where, as here, Congress acted under "a power * * * delegated to Congress in the Constitution." *New York* v. *United States*, 505 U.S. 144, 156 (1992). This case fits the classic model of preemption: EMTALA "imposes restrictions or confers rights on private actors," and Idaho law "imposes restrictions that conflict with the federal law." *Murphy* v. *NCAA*, 584 U.S. 453, 477 (2018).

c. Petitioners emphasize the States' traditional authority over health and medicine. Idaho Br. 19-20; Leg. Br. 54. But "there is no question that the Federal Government can set uniform national standards" on matters of "health and safety," including "medical practice." *Gonzales* v. *Oregon*, 546 U.S. 243, 271 (2006). That is what Congress did in EMTALA, and the statute's express preemption provision makes clear that those standards override contrary state law.

That the emergency care required under EMTALA sometimes includes pregnancy termination does not alter that conclusion. In *Dobbs*, this Court "returned" "the authority to regulate abortion * * * to the people and their elected representatives." 597 U.S. at 292. After *Dobbs*, even most States with restrictive abortion laws include an exception allowing pregnancy

termination in some circumstances involving risks to the pregnant woman's health. A few, including Idaho, do not.[11] But the people's elected representatives also include their representatives in "Congress." *Id.* at 345 (Kavanaugh, J., concurring). And those representatives enacted EMTALA, which requires hospitals to offer pregnancy termination when necessary to avoid grave harm to a woman's life or health and unequivocally preempts "any" state law that "directly conflicts" with that requirement. 42 U.S.C. 1395dd(f). If Congress wishes to revisit EMTALA in light of States' greater authority to regulate abortion after *Dobbs*, it is free to do so. But nothing in *Dobbs* provides any reason to depart from EMTALA's plain text or ordinary preemption principles.

d. Finally, petitioners err in asserting that adhering to EMTALA's plain text would "offend[] the major questions doctrine," Leg. Br. 38 (emphasis omitted); see *id.* at 38-48; Idaho Br. 21-22. That doctrine applies when an "agency" asserts an "extraordinary grant[] of regulatory authority." *West Virginia* v. *EPA*, 597 U.S. 697, 723 (2022). It is rooted in a presumption that Congress would speak clearly if it meant to "delegate a decision" of vast "economic and political significance to an agency." *FDA*

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[11] Seven States (including Idaho) have laws that lack a health exception. See Ariz. Rev. Stat. § 13-3603; Ark. Code Ann. § 5-61-304; Miss. Code Ann. § 41-41-45; Okla. Stat. Ann. tit. 21, § 861; S.D. Codified Laws § 22-17-5.1; Wis. Stat. § 940.04. But several of those laws are in flux. The Arizona Court of Appeals, for instance, has held that Arizona's Civil-War-era ban was supplanted in relevant part by more recent laws. *Planned Parenthood Ariz., Inc.* v. *Brnovich*, 524 P.3d 262, 268-269 (Ariz. Ct. App. 2022). And the Wisconsin Attorney General has challenged Wisconsin's 1849 ban in state court. *Kaul* v. *Urmanski*, petition to bypass pending, 23AP2362 (filed Wis. Feb. 20, 2024).

v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000). But this is not an agency-delegation case. We do not argue that Congress vested HHS with authority to decide whether pregnancy termination can qualify as necessary stabilizing care, or that the agency is entitled to any deference on that question. Instead, this suit simply seeks to enforce "policy decisions" made by "Congress * * * itself" in EMTALA. *West Virginia*, 597 U.S. at 723. That presents an ordinary question of statutory interpretation, and this Court should resolve it using ordinary principles of statutory construction. The mere fact that a question of statutory interpretation is consequential or controversial has never been a reason to put a thumb on one side of the interpretive scale. See, *e.g.*, *Brnovich* v. *DNC*, 141 S. Ct. 2321 (2021); *Bostock* v. *Clayton County*, 590 U.S. 644 (2020).

In any event, this case bears none of the hallmarks of the handful of "extraordinary cases" where this Court has invoked the major-questions doctrine. *West Virginia*, 597 U.S. at 723. Most fundamentally, EMTALA's requirement that providers offer essential stabilizing care in emergency situations is not framed in "vague," "cryptic," "ancillary," or "modest" terms. *Id.* at 721, 723, 724 (citations omitted). To the contrary, EMTALA mandates in no uncertain terms that a hospital "must provide" the treatment "required to stabilize" an "emergency medical condition." 42 U.S.C. 1395dd(b). And that clear text perfectly reflects the statutory "context" and "history." *Biden* v. *Nebraska*, 600 U.S. 477, 511, 517 (2023) (Barrett, J., concurring) (citation omitted): EMTALA's stabilization requirement—assuring emergency care for all—was the promise at the very heart of the Act.

Nor is there anything "transformative," Leg. Br. 42 (citation omitted), about interpreting the stabilization requirement to mean what it says: stabilization is required. To the contrary, that is how EMTALA has long been understood by all relevant entities for nearly four decades. See pp. 16-20, *supra*. Indeed, it is petitioners who would upset long-settled understandings by transforming EMTALA into a mere nondiscrimination rule, allowing States to override its requirements, or reading in an implicit exclusion of a particular stabilizing treatment even when it is the only care that will protect pregnant women's lives and health.

The fact that the stabilizing treatment at issue here involves pregnancy termination does not justify invoking the major-questions doctrine. This case does not involve whether States can prohibit abortion generally; instead, it concerns the narrow question whether States can deny pregnant women essential medical care to prevent grave harm to their health notwithstanding EMTALA's stabilization mandate. That issue is profoundly important for pregnant women and the providers who treat them in emergencies—but it is a discrete question of statutory interpretation that arises only in rare circumstances and does not broadly implicate the national debate on abortion policy.

At bottom, petitioners ignore that the major-questions doctrine is a tool for discerning, not frustrating, Congress's intent. The Congress that enacted EMTALA in 1986 had no reason to speak more "clear[ly]," Leg. Br. 42 (emphasis omitted), to ensure that emergency care could include pregnancy termination—like all other medically required care. At the time, no State could have banned the care required by EMTALA. *Dobbs* did not retroactively change EMTALA's meaning or

transform that straightforward application of the Act's text into a "major question."

* * * * *

In many pregnancies where serious complications arise, the pregnancy was deeply wanted—and the mother fervently hoped it would lead to a healthy child. But for a host of reasons, pregnancy can sometimes lead to an urgent medical crisis. When that happens and continuing the pregnancy seriously threatens the mother's health, termination of the pregnancy is essential medical care—like any care that any other person with any other condition would seek and receive in a hospital emergency room. EMTALA's plain text promises such care to everyone, including pregnant women. This Court should reaffirm that Congress's promise means what it says.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

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APPENDIX

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APPENDIX

42 U.S.C. 1395dd provides:

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[1] 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,

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[1] So in original. Probably should be followed by a comma.

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 em-

ployee because the employee reports a violation of a requirement of this section.