UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS, et al., Plaintiffs,
VS.
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services, et al., Defendants.

CAUSE NO. 5:22-CV-185-H

EVIDENTIARY HEARING
BEFORE THE HONORABLE JAMES WESLEY HENDRIX,
UNITED STATES DISTRICT JUDGE

AUGUST 18, 2022
LUBBOCK, TEXAS

FEDERAL OFFICIAL COURT REPORTER: MECHELLE DANIEL, 1205 TEXAS AVENUE, LUBBOCK, TEXAS 79401, (806) 744-7667.

PROCEEDINGS RECORDED BY MECHANICAL STENOGRAPHY; TRANSCRIPT PRODUCED BY COMPUTER-AIDED TRANSCRIPTION.

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P R O C E E D I N G S

THE COURT: Good afternoon, everyone. Welcome to the U.S. District Court for the Northern District of Texas. We're here for an evidentiary hearing. And the Court calls State of Texas vs. Becerra, Case 5:22-CV-185. Give me one second to make sure I'm squared away.

Who is here on behalf of Plaintiffs?

MS. HILTON: Good afternoon, Your Honor. Amy Hilton and Charlie Eldred and Mr. Wassdorf for the State of Texas, and Mr. Bangert for the co-plaintiffs.

THE COURT: All right. Ms. Hilton, Mr. Eldred, it's good to see you again.

And it was Mr. Wassdorf; is that right?

MR. WASSDORF: Yes, Your Honor.

THE COURT: Nice to-- Have we met before?

MR. WASSDORF: No, Your Honor.

THE COURT: It's nice to meet you. Thank you for being here.

And, Mr. Bangert, thank you for being here.

And who is here on behalf of the defendants?

MR. HEALY: Christopher Healy for the United States. And I'm here with my colleagues Eric Beckenhauer, Kate Talmor, and Alex Ely.

THE COURT: Okay. Thank you. And I don't believe we've met before, have we?

MR. HEALY: No.

THE COURT: All right. Well, it's nice to meet you all. Thank you for being here.

Who will be arguing on behalf of the State of Texas?

MS. HILTON: Your Honor, Mr. Eldred and I will both be arguing on behalf of the State.

THE COURT: Okay.

MS. HILTON: And Mr. Bangert will be addressing arguments particular to his clients.

THE COURT: I understand. How have you decided to divide up your one hour?

MS. HILTON: We have decided that I will take up to twenty minutes, Mr. Eldred will take ten, Mr. Bangert will take ten, and we'll reserve the rest for rebuttal.

THE COURT: All right. You will take twenty, Eldred will take ten, Bangert will take ten--

MS. HILTON: Oh--

THE COURT: I'm sorry.

MS. HILTON: Excuse me. I'm sorry, Your Honor. Mr. Bangert will take twenty as well. Ten minutes for rebuttal. I'm sorry.

THE COURT: Twenty, ten, twenty. Correct?

MS. HILTON: Yes, Your Honor.

THE COURT: Okay. No problem. I'm bad with math,

so I'm sure my law clerks will help me. And you're reserving ten for rebuttal. Each of you-- I'll just ask, who's going to do rebuttal?

MS. HILTON: Yes, Your Honor, I'll do rebuttal.

THE COURT: Okay. Got it. Reserving ten. Okay.

And who is arguing on behalf of the United States? Mr. Healy?

MR. HEALY: I'll be presenting.

THE COURT: Okay. Great.

All right. On the time limits, I wanted to provide some structure for this. Let me ask, is either side planning to call witnesses or present any additional evidence other than the declarations?

MS. HILTON: No, Your Honor.

THE COURT: Mr. Healy?

MR. HEALY: No, so long as Plaintiffs aren't.

THE COURT: Okay. So--and no objections to defense declarations, I assume, or no?

MS. HILTON: No, Your Honor. I think the--I believe the parties have agreed that we will just proceed on declarations today in lieu of live witness testimony.

THE COURT: All right. Is that right, Mr. Healy? No objections to the plaintiffs' declarations?

MR. HEALY: No objections.

THE COURT: All right. All the declarations from

both sides will be admitted into evidence and considered by the Court. No additional evidence will be provided today. So we just have oral argument on the parties' briefing and evidence that's been submitted to the Court.

I gave each side one hour each, just to give some general guardrails here, so it's not just a Zoning Commission hearing where everybody can talk as long as they want. But know thyself. I know I'm going to have a lot of questions. No doubt I'll interrupt you both. Know that those questions are just giving you an opportunity to help the Court. They are good-faith questions trying to help understand what's before me.

I will give you additional time as necessary. I've cleared my docket. I cleared a criminal docket in large part that I had today because I wanted to give you the attention that both of you deserve. I know it's an important case. I know it's an emotional case. I want you to be able to say everything you want to say. So if time has expired and there's some critical point that you want to make, just let me know. Okay? Understand, Ms. Hilton?

MS. HILTON: Yes, Your Honor.

THE COURT: Mr. Healy?

MR. HEALY: Understood. Thank you.

THE COURT: Okay. All right. Of course.

All right. I'm not sure--I don't see any members

of the press here. No, I don't. In case they come in, just for the CSOs and the marshals, they are welcome here. They are allowed to have electronic devices for note-taking. No recording of any kind, no auto-dictation of any kind through a program. No live streaming one way or the other, including via social media.

All right. I want to alert both sides also that before I ask questions, I'll give both sides a couple minutes to make any kind of just general big-picture opening statement. But I do have some threshold questions for both sides, but I'll let you give me an overview beforehand.

Okay. Ms. Hilton, do you plan to start?

MS. HILTON: Yes, Your Honor. And if I may, I have a quick housekeeping matter that I'd like to bring up with the Court.

THE COURT: Sure.

MS. HILTON: Last night, Plaintiffs filed their reply in support of our motion, and it is--due to a lot of stress and trying to--working late and meeting that deadline, it is one paragraph over the Court's page limit. And so-- That is our fault. It was certainly not intentional to exceed the Court's limit. And so I would just ask--and Mr. Healy--if we might have leave to include that extra paragraph, or, if the Court prefer, we can refile excluding that.

THE COURT: Okay. There's a motion for leave to

allow extra-length brief by one paragraph. Any objection, Mr. Healy?

MR. HEALY: We have no objections.

THE COURT: It's good advocacy not to oppose when it would be unreasonable to oppose.

MR. HEALY: Yeah, honestly, I didn't even notice.

THE COURT: Well, good. What I thought you were going to say--and we'll just address this too--it was filed two minutes after midnight, at least on our end. I assume there's no objection from that as well, Mr. Healy. Is that right?

MR. HEALY: No objection.

THE COURT: Yeah. So the brief is obviously going to be considered. I saw that and just chuckled to myself. As a former appellate chief, one of my law clerks was a former paralegal at a big firm, and he had great anxiety about a brief being filed two minutes past midnight, because--

MS. HILTON: Thank you, Your Honor. There was great anxiety on our side as well.

THE COURT: Yeah. No. It's happened to all of us. We can all be gracious with one another to the extent that we can.

Just one final thing. I mean, I appreciate both sides' professionalism and briefing. Again, I know that both sides--this matters deeply to the State of Texas and to the United States, to the amici on both sides. There have been

hard blows thrown by both sides. No foul blows, as far as I can tell. I know that will continue to be the case. So thank you for your professionalism and courteousness.

All right. Ms. Hilton, at the podium, please. It is 1:10. Whenever you're ready. I'll give you a two-minute warning when you're getting close to your twenty minutes. If you need to keep going, that's fine. You will just cut into Mr. Eldred's time.

MS. HILTON: Thank you, Your Honor.

May it please the Court. EMTALA takes state law as it finds it. We are here because the abortion mandate is telling Texas hospitals and physicians that that's not the case and they must perform abortions in a number of circumstances that exceed what Texas law allows.

Under the abortion mandate and according to the defendants' briefing, EMTALA deputizes hospitals and physicians to be their own lawmakers and veto any state law that attaches any standards to their provision of care. The abortion mandate promulgated by the defendants exceeds their statutory authority and is contrary to the Constitution. The plaintiffs respectfully request that the Court grant their preliminary injunction because they are suffering irreparable harm, they will suffer irreparable harm as a consequence of this mandate, and the plaintiffs are likely to succeed on the merits of their claim, and the balance of the equities weighs in favor of

maintaining the status quo.

At the heart of Plaintiffs' claims and the parties' dispute is what EMTALA does and does not require. It requires hospitals and physicians to provide appropriate medical screening and stabilizing treatment for emergency medical conditions. When it enacted EMTALA, Congress was addressing what some courts have described as a national scandal in which hospitals were refusing to treat patients because of their inability to pay. And so that's why EMTALA was passed. And while it does require that physicians and hospitals provide sufficient stabilizing treatment, it leaves the adequacy of that care up to state law.

THE COURT: Doesn't the statute define stabilization?

MS. HILTON: Yes, Your Honor, it does. But it does not--it does not dictate what that stabilization has to be or how the physician or hospital must provide it.

THE COURT: You cite cases for that proposition. Correct?

MS. HILTON: Yes, Your Honor. We have--

THE COURT: That there's--that the statute doesn't set a national standard of care?

MS. HILTON: Yes, Your Honor, we do have cases in our briefing.

THE COURT: As I read those cases, those are all--I

think, all screening cases, so they're cases that focus on the screening requirement. And absolutely, I think case law is abundantly in your favor on the idea that, when a hospital screens someone, their obligation is to be uniform. They can't screen an indigent patient in a different way than they would screen someone with Blue Cross Blue Shield who can pay.

But there are also a few circuit court cases that say that the stabilization is different. Stabilization is defined in the statute; there can't be--you can't allow a material deterioration of--I can't remember the exact language, but I'm paraphrasing.

Because it's defined in the statute, I mean, are you saying that if a state just chose, "You know what, like, treating heart patients is really expensive, we're just not going to treat any of them, we're not going to stabilize anybody," wouldn't that still be a violation of the statute? If an indigent person came in with a heart attack or, fill in the blank, EMC for a heart condition, they don't treat that indigent person, and the state said or the hospital said, "We don't treat anybody, it's uniform," get-out-of-jail-free card, or no?

MS. HILTON: No, Your Honor. That is a distinction-- You're absolutely correct. It is a different standard. Screening is--it has to be the same screening regardless of ability to pay. The sufficient stabilizing

treatment, the way that I view the--I have read the case law, would be that you still would provide the same treatment to someone who would be unable to pay, so there's still that equality. But certainly, you're correct, you still must provide that stabilizing treatment, but the sufficiency of it and what that is would be bounded by the state law in which that hospital is located.

THE COURT: Okay. So stabilization is defined, but you're arguing that--so you can't allow a material deterioration before either stabilization or transfer. What authority do you have that state law defines material--what is material deterioration and what's not? That that's a function or derivative of the state or the hospital?

MS. HILTON: Yes, Your Honor. So two things. I believe we cited one case. It is a Fourth Circuit case, but it's *Bryan vs. Rectors and Visitors of the University of Virginia* that talks about whether the hospital had complied with its duty to provide sufficient stabilizing treatment. And the Court sort of punted and said, this is not really--this is a--sort of a malpractice zone. This would be what would be the State--what the State would require under that certain medical--for that certain medical condition.

And then secondly, I think it's also reflected in EMTALA itself in the enforcement provisions. In 1395, Congress set out in the statute that patients could bring private causes

of action for care that didn't meet the requirements of EMTALA, and it says that it would refer to state law for malpractice also there.

So I think there's case law, and I think it's also supported by the text of the statute.

THE COURT: There's also a piece of the statute, as I recall, that says a hospital or a doctor must provide the treatment--again, I'm paraphrasing--to the extent they're capable. I mean, if they literally are incapable of providing some very high-level, MD Anderson level or Mayo Clinic level of stabilization and it's a rural hospital, they're not going to--it's not going to be held against them. Is that right?

MS. HILTON: That's correct, Your Honor.

THE COURT: Okay. All right. Let me ask a few threshold questions before we get further into your argument. I asked both parties to prepare to explain their definition of abortion, and their authority for it. Do I assume correctly that you're using the definition that's in the Health and Safety Code?

MS. HILTON: Yes, Your Honor. That, and Texas has defined and regulated abortion in two places, both in the Health and Safety Code, which the Texas Human Life Protection Act incorporates the Health and Safety Code definition.

THE COURT: Okay.

MS. HILTON: And so that's one place where it's

defined. And then the second place where it's defined is in Texas' pre-Roe criminal statutes that provide their own definition as well. And so it's in those two--in those two statutes.

THE COURT: Are those materially the same? Is there any material difference between any of them that would matter in this case?

MS. HILTON: There are differences, but not that would matter in this case, no.

THE COURT: Okay. Do they all require an intervention of some kind by a licensed physician? The doctor is doing something?

MS. HILTON: I'm sorry, Your Honor. Could you say that--

THE COURT: The doctor is doing something. Do all the definitions require some sort of medical intervention by a physician?

MS. HILTON: Yes, Your Honor. Yes, it must be--both of them require--if it's going to save the life of the mother, it is the intervention of a doctor, yes.

THE COURT: Okay. Is there an intent to terminate a suspected or known pregnancy? Is that a piece of all the definitions? And if you don't know, that's fine, but--

MS. HILTON: It is, Your Honor. Under the pre-Roe criminal statutes, it's the intent to terminate the life of the

fetus. So, yes, I think that's consistent.

THE COURT: Are all of the definitions intrauterine?

MS. HILTON: Yes, Your Honor.

THE COURT: It is an intrauterine pregnancy?

MS. HILTON: Yes, Your Honor.

THE COURT: Okay. And then finally, just that produces--that does not result, pardon me, in a live birth?

MS. HILTON: I'm sorry. So if abortion-- Oh, yes, exactly. Correct, yes.

THE COURT: It produces a non-live child, or fetus.

MS. HILTON: Yes.

THE COURT: Okay. Areas of agreement, potentially. The medical associations' amicus brief, along with some of the briefing from the United States, give lots of examples of concerns of, the following things won't be able to happen in Texas if their guidance memo and their view of EMTALA doesn't prevail here. For example, the first one listed often is a tubal ectopic pregnancy. That's in, I think, their brief, but also the medical associations' amicus brief. Is that immediately treatable under Texas law, and how?

MS. HILTON: Yes, Your Honor, under both the pre-Roe criminal statutes and the Human Life Protection Act.

THE COURT: Okay. So Texas agrees that a tubal ectopic pregnancy, treatable, regardless of EMTALA, Texas law

permits that?

MS. HILTON: That is correct, Your Honor.

THE COURT: Okay. Also, obviously treatable under EMTALA?

MS. HILTON: Yes, Your Honor.

THE COURT: So-- Okay. So there's an area of agreement. Does that constitute an abortion in Texas? Treatment of a tubal ectopic pregnancy?

MS. HILTON: No, Your Honor. It is--under the Human Life Protection Act, it is not an abortion if it is to save the life of the mother or to remove an ectopic pregnancy.

THE COURT: Okay. So when amicus medical associations say, "We're very concerned, tubal ectopic pregnancies," the State answer, as I just understand it, say, "No problem at all, that's not an abortion in Texas, treat it."

MS. HILTON: That is correct. Under the pre-Roe criminal statutes, it would not be an offense, because it would be to save the life of the mother. And then under the Human Life Protection Act, it is just simply not an abortion.

THE COURT: Okay. What about a miscarriage? That's another example from--I think it's in the United States' brief. It's definitely in the medical associations' amicus brief on one of their bullets. Treatment of a miscarriage.

MS. HILTON: Under Texas law, the removal of a dead unborn child is not an abortion.

THE COURT: Okay. So not an abortion. So treatable under Texas law, treatable under EMTALA, just not an abortion?

MS. HILTON: That's correct, Your Honor.

THE COURT: Okay. So to the extent there are concerns about that, you agree that we have another area of agreement? I mean, I'm going to hear Mr. Healy out, of course, but I think he'll be glad to hear that Texas is not going to raise any objection to treatment of miscarriages.

MS. HILTON: Correct. Yes. If a miscarriage, yes, is removal of the dead unborn child, yes.

THE COURT: Okay. Another one is a prelabor rupture of membranes. The medical associations' amicus doesn't go into great detail about exactly what they mean, but are you--and if this is too far in the weeds, fine. But do you know whether that would be immediately treatable in Texas, and how?

MS. HILTON: If it were threatening the life of the mother, then yes.

THE COURT: Okay. What about if it poses a serious risk of substantial impairment of a major bodily function, which I understand is another piece of the Texas law?

MS. HILTON: Yes, Your Honor, that is treatable.

THE COURT: Okay. So also treatable there?

MS. HILTON: Yes, that's correct.

THE COURT: Okay. Would it be an abortion?

MS. HILTON: That is an abortion under Texas law; it's just not prohibited.

THE COURT: Got it. Okay. So the first two that we discussed, not an abortion. This, an abortion, but treatable if it's threatening the life of the mother or poses a serious risk of substantial impairment of major bodily function?

MS. HILTON: That's correct.

THE COURT: Okay. The final one that I have that was listed in the briefing is prompt care where miscarriage is suspected. The medical associations' amicus is concerned about that, and they have specified: to avoid development of sepsis. So I suppose--I guess this hypothetical is, a woman has miscarried or suspected of miscarrying; concerned about an infection resulting in sepsis.

MS. HILTON: Under Texas law, this would leave it to a physician whether that was threatening the life of the mother.

THE COURT: Okay. So same answer as last time? If the life is threatened or there is the serious risk of substantial impairment, then they're within the law; they can treat it however they need to treat it, including an abortion?

MS. HILTON: That is correct.

THE COURT: Okay. All right. That's areas of

agreement, potentially.

Areas of disagreement. What medical procedures do you believe would be required under EMTALA, under emergency medical condition, that would not be allowed by Texas law? Where is there daylight between the two?

MS. HILTON: Yes, Your Honor. So under EMTALA, under the statute itself, there is no daylight between-- EMTALA itself, as a statute, without the guidance, does not require an abortion under any certain circumstance. It doesn't dictate any certain medical procedure or treatment. And so, in that sense, there is no daylight between EMTALA and Texas law.

THE COURT: Say that again. I think you just said because EMTALA doesn't require an abortion ever?

MS. HILTON: That's correct, Your Honor.

THE COURT: Was that the answer?

MS. HILTON: That's correct. The statute does not allow the federal government, or any of their officers or employees, to provide any sort of supervision or oversight on medical care or medical treatment. And the statute itself-- This is something that the parties agree on. EMTALA, the statute, does not reference abortion. It doesn't reference any particular type of medical procedure. And so, in that sense, there's no daylight between EMTALA and Texas law. The daylight is between the guidance that the defendants issued and Texas law.

THE COURT: Okay. Okay. A couple of questions there then. One, what is that daylight? And, two, in the example that--or one of the examples we just discussed, say prelabor ruptured membranes, you noted that--treatable under Texas if the two exceptions of Texas--either of the two exceptions are satisfied. And in that case, it would be an abortion. If that woman walked in who's indigent, would EMTALA allow a doctor or require a doctor to stabilize her through an abortion? Just like Texas law permits this procedure, EMTALA would also require this procedure? And--

MS. HILTON: EMTALA would require the hospital to stabilize the woman if it is an emergency medical condition. And under Texas law, that would allow the physician to--if it's threatening the life of the mother, to terminate the pregnancy.

THE COURT: Okay. So both EMTALA-- I think I understand the needle you're trying to thread here. EMTALA requires stabilization in this example. Let's just assume prelabor rupture; life of the mother is at risk; all the other Texas requirements are satisfied; an abortion would be permitted. Abortion is the stabilizing treatment also under EMTALA?

MS. HILTON: I think it's a little bit of a distinction, Your Honor. I think, if I'm following correctly, EMTALA would require stabilizing treatment. What that treatment is would be defined by state law. And so the--once

there's a physician/patient relationship that attaches, that treatment then--the physician, in his or her medical judgment, whatever the stabilizing treatment is would be guided by state law and not by EMTALA, although EMTALA would require them to stabilize in compliance with state law.

THE COURT: Okay. What if-- All right. I understand your argument. That's helpful. Thank you.

What if an indigent patient walks into a hospital. The only stabilizing treatment in 20 years is some very novel stem cell treatment that derives from fetal tissue, and a state just makes an ethical decision that that's not a line we want to cross; we're not going to allow that. And that's the only treatment for this very rare emergency condition. Indigent patient walks in, stabilization, those stem cells that could be acquired if they wanted them; state law says no. Does EMTALA preempt the state law in that circumstance?

MS. HILTON: No, Your Honor. The preemption requirement under EMTALA would only apply to the terms of EMTALA itself. All that EMTALA requires is the-- It's the same care that would be provided, the screening that's the same for everybody. And then the sufficient medical treatment would be determined by state law. If state law says no one gets this emergency treatment, then it wouldn't be a violation-- There's nothing in EMTALA that would require that specific treatment.

THE COURT: EMTALA would require a doctor to say, I

can't allow this patient to materially deteriorate? I hope I'm getting that language right. I think you know. The stabilization language. That's my obligation as a doctor under EMTALA. Patient before me; if I don't give them this, you know, fill-in-the-blank controversial treatment, they will deteriorate. It's certain that they will. But state law tells me I can't because of this ethical decision.

What does the doctor do?

MS. HILTON: The doctor would have to do whatever is the accepted medical standard in the state.

THE COURT: Okay. In your view, that's not a violation of the stabilization requirement, because stabilization is defined by state law? Or it looks to state law for--

MS. HILTON: Yes. That's exactly correct, Your Honor. The preemption requirement in EMTALA is a direct conflict preemption, and so requiring stabilizing treatment is not requiring any particular treatment. So it wouldn't--there would be nothing in EMTALA that would say they must get this particular treatment, because this is what stabilizing treatment is. What stabilizing treatment is would be defined by state law, and that's--I mean, yes, so--

THE COURT: Okay. All right. Okay. That's helpful. Thank you.

Okay. Let me ask this. You've been in my court

before. You know there are going to be more questions. I know it's--I know the experience of being peppered with questions; then trying to figure out where to go next. So let me--while you're thinking, let me ask another one.

You mentioned earlier--you clarified, well, Your Honor, it's not the definition of EMC where there's daylight; it's the memo. Tell me about that daylight. Where is the daylight between Texas' exceptions for permissible abortions and what the memo would require?

MS. HILTON: There are at least three different ways that the guidance requires what Texas law prohibits. So the first--the abortion guidance, the mandate, on page 3, says that an emergency medical condition includes this undefined situation in which the health of the pregnant woman is in serious jeopardy, but her life is not. Under Texas law, it would require that the woman's life be in danger. And so that's one. This--

THE COURT: Okay. Let me jump in-- I'm sorry. Was there more on that one?

MS. HILTON: Oh, yes, Your Honor.

THE COURT: Okay. Go ahead.

MS. HILTON: This--in the guidance, this leaves open the possibility that a woman--pregnant woman presents with a mental health crisis, and the mental health crisis is stemming from, she doesn't want to carry this child to term.

And so under the mandate, it would--this would be--You know, the woman's health is in serious jeopardy. This stabilizing treatment would be an abortion. Under Texas law, that would be prohibited, because it's not her life that's at risk.

THE COURT: Okay. So the way you read the Texas law--well, the way Texas views its law is that, even though there's the second piece about posing a serious risk of substantial impairment of a major bodily function, that also goes back to the earlier phrase, life-threatening? I mean, the bottom line in both circumstances, a life-threatening condition is required?

MS. HILTON: It must be life-threatening. And in addition to that, Your Honor, the Human Life Protection Act specifically says that a physician may not perform an abortion if the reason that, you know, the mother's life is at risk is because she's threatening harm to herself.

THE COURT: Right.

MS. HILTON: And so that would be another situation which there's daylight between the mandate and Texas law.

THE COURT: Okay. So just general health in jeopardy, that's so broad--

MS. HILTON: Yes.

THE COURT: --under the memo and guidance that it could include things like mental health and a person might hurt

themself because they're in a panic about being pregnant. Not permissible under Texas law; would be required, in your view, under the guidance and letter?

MS. HILTON: Yes, Your Honor.

THE COURT: Okay. What's the second?

MS. HILTON: The second, Your Honor, is, the abortion mandate also stipulates that an incomplete medical abortion is an emergency medical condition that requires physicians to complete the abortion. And that is--obviously that's not the threat to the life of the mother. And so that's also another distinction between the guidance and Texas law.

THE COURT: Okay.

MS. HILTON: And then finally, Your Honor, there's additional language in the guidance that expands on emergency medical conditions to include a situation that's likely to become emergent. And this is so vague that this is--this would also take it outside of a threat to the life of the mother.

THE COURT: So someone has preeclampsia or--I'm struggling to think of another example, but that is serious but it hasn't become emergent, an emergency yet. It likely could. Likely to become emergent under the memo. The memo would require, if it prevailed and were binding, an abortion; Texas law would not require that? Texas law would be wait and see?

MS. HILTON: Yes, Your Honor. There would be--in that situation, under the guidance, the defendants are

requiring that physicians offer and provide all potential stabilizing treatment. And then if that's abortion--or abortion can be one of those. If that's what's elected, that must be provided.

THE COURT: Okay.

MS. HILTON: And so that's absolutely correct, Your Honor.

THE COURT: All right. Understood.

Okay. You're already at 20 minutes. That's all my fault, so I'm going to give you back some time. I'll add some time to the United States. Go ahead. What else do you-- Go ahead.

MS. HILTON: Thank you, Your Honor. Let me move to just make a couple of brief points. The defendants are challenging Texas' standing to bring this. And I want to just bring to the Court's attention, there's some dispute about whether Texas has parens patriae standing to bring this lawsuit. And not only does this mandate interfere with Texas' ability to create and enforce its own legal code for the reasons that we've just been discussing, but also, because the guidance threatens to terminate CMS provider agreements and exclude physicians from state health programs, from Medicaid and from Medicare, it's threatening billions of dollars to Texas hospitals.

And if those--if we have widespread, you know,

hospitals that are no longer Medicare and Medicaid providers, that's threatening--it's shuttering hospital access to Texans across the state, and particularly those who need it most. And so that would be Texas' interest in protecting the health and well-being of its own citizens in that case.

THE COURT: Okay.

MS. HILTON: I think I'm going to move to the Court's second--

THE COURT: Before we leave standing-- And again, I'm going to give both sides more time. But were you going to--were you going to move away from standing?

MS. HILTON: I was, but we can stay there.

THE COURT: Okay. Yeah, let me ask a few follow-up questions.

The defendants assert this letter is meaningless. The guidance is meaningless; we're just telling you what we think the statute means anyway; it's not binding. They've now said it in a public filing that it's not binding. It's meaningless. If you pull it or enjoin it, Court, so what? We still think the statute means what it means.

And so how are you injured by something that they have said publicly has no effect?

MS. HILTON: Your Honor, I think that those statements are belied by the federal government's actions enforcing this guidance against the State of Idaho. They

specifically cite the guidance, I believe, on paragraph 24 of that lawsuit, of their complaint. And so they are absolutely enforcing it. The Attorney General, earlier this month, came out with a statement saying that they were going to aggressively protect reproductive rights and mentioned this lawsuit, as well as the Idaho lawsuit, and said that this was--you know, they were going to counteract *Dobbs* in this way.

In addition, Your Honor, the guidance itself does not simply restate the law or what EMTALA requires. It is, for all the reasons-- We've just gone through some hypotheticals about what the guidance requires in terms of abortion. But EMTALA has never required any specific procedure or any specific treatment. And so the idea that this mandate is now saying stabilizing treatment is abortion, that is--exceeds their statutory authority, and it's certainly something that the defendants are enforcing in another state right now.

THE COURT: Yeah, and in your view, that's final agency action; it's gone beyond the scope of the statute, and so, at the very least, there's a notice-and-comment violation, if not just a complete dead letter because it was invalid or unauthorized in the first place.

Assuming I find a notice-and-comment violation, what's your best evidence or authority that you have standing for that?

MS. HILTON: Your Honor, because the mandate

threatens Texas' concrete interest in enforcing its own law, that is a--Texas has standing to challenge the procedural violation. This rule intrudes on Texas' ability to enforce its own legal code, and Texas was not allowed to engage in the rulemaking process in notice and comment. Certainly it would seem, after *Dobbs* in particular, that a mandate of this scope--certainly the public would like to comment in the different states, as they all have different abortion regulations and prohibitions.

THE COURT: Okay. You mentioned the Idaho suit. I thought the Idaho suit--the United States was basing that just on EMTALA, and not on the memo itself. Am I wrong about that? It's referenced in paragraph 24?

MS. HILTON: It is referenced in paragraph 24, and the way in which the lawsuit reads is to-- It's the same requirements as the guidance, that EMTALA requires abortions. Abortions--abortion is the stabilizing treatment for certain conditions and must be provided. And so there's the citation, but also, the characterization of what EMTALA requires is a mirror image of what the guidance is.

THE COURT: I see. So the United States is representing in the lawsuit that EMTALA requires X, Y, and Z. That mirrors the guidance and letter, and they cite the guidance and letter as authority for what it requires?

MS. HILTON: Yes, Your Honor.

THE COURT: Okay. That's helpful. All right. I understand.

Final question on standing and potential for injury and whether it's concrete or not. There's a lot of discussion in the letter about a doctor's discretion; if, in the doctor's discretion, he or she finds X, Y, or Z, and he or she finds that stabilization is abortion, then they must produce an-- Does the discretion that's built into the guidance and letter undermine your standing argument?

MS. HILTON: No, Your Honor, it doesn't. On page-- I believe it's 5 of the guidance, it says: Physicians and hospitals have an obligation to follow the EMTALA definitions, even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located. Hospitals and physicians have an affirmative obligation to provide all necessary stabilizing treatment options to an individual with emergency medical condition.

And so this--the discretion is sort of swallowed by that statement.

THE COURT: Okay. All right. I understand.

Where would you like to turn?

MS. HILTON: Your Honor, I think I'm going to turn to the APA claims just briefly. We've talked already about notice and comment. And I want to-- Mr. Eldred is going to be

addressing the Constitutional claims, which go towards--which also go to the reasons why the guidance exceeds statutory authority and is not in accordance with law. But I did want to point out a couple of things.

First, as I've mentioned and as the parties agree, 1395 includes a provision that prohibits the defendants from exercising any supervision or control over medical treatment. And then another thing is-- So the guidance contradicts itself--contradicts EMTALA in two ways: first, in dictating a particular medical treatment in violation of the statute itself.

And then secondly, on page 3 of the guidance, the definition of emergency medical condition, the defendants have actually omitted the consideration of the unborn child. And so the guidance has changed the definition of what an emergency medical condition can be.

Under the guidance, it says an emergency medical condition, you know, is one in which it places the health of a person, including pregnant patients, in serious jeopardy. But under the statute, it says--it places the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. And so the guidance has just removed the consideration of the unborn child completely from the physician's obligations under EMTALA.

THE COURT: And therefore?

MS. HILTON: Well, so, Your Honor, one of the--it goes to one of the examples that is provided in the guidance. On page 5 and 6, the defendants state that an incomplete abortion is an emergency medical condition that requires stabilizing treatment, would be requiring completion of the abortion.

Under EMTALA, without the guidance, a physician would be required to preserve the health of the unborn child. But now, under the guidance, by removing consideration of the unborn child from the definition of emergency medical condition, now the stabilizing treatment is the completion of the abortion, regardless of whether an ongoing but incomplete abortion could be reversed.

And then Defendants double-down on that in Footnote 3 of their brief by saying that states cannot administer a drug that would reverse an ongoing, but incomplete, medication abortion.

And so that's another reason why this guidance conflicts with EMTALA itself. It exceeds the statutory authority. It's not--it doesn't--it's not in accordance with law.

This is also--the EMTALA guidance is also arbitrary and capricious. This hasn't--neither party has really briefed this up in a major way, but I think it's very significant just to bring to the Court's attention the different public

statements that have been made by the federal government about what the purpose of this guidance was. It was distributed in the wake and in response to *Dobbs*. It was part--it has been part of a larger sort of mobilization of agencies to require abortions here, to say that pharmacies cannot refuse to stock or dispense abortifacients, and the Attorney General, just a couple of weeks ago, announced that this was part of their effort to aggressively combat the Supreme Court's ruling in *Dobbs*.

And so this is not a case where the agency engaged in rulemaking and actually saw a problem, like pregnant women were being denied care under EMTALA and that there was any sort of risk to women in that sense and so they had to issue this guidance. This was purely in response to *Dobbs*.

My colleague, Mr. Eldred, is going to address the Court's third question, but I did want to--before I pass to Mr. Eldred, to answer the Court's fourth question about the proper scope of an injunction. Of course, this is a conversation that you had with Mr. Eldred last fall when we were in this court. And certainly, Texas understands that the Court is reticent to issue a nationwide injunction in light of some recent Fifth Circuit precedent limiting injunctions to the named parties.

In this case, Texas believes that a nationwide injunction would be appropriate for a couple of reasons.

First, under the APA, even just the failure to provide notice and comment, the APA would require the Court to set it aside, and--

THE COURT: Nationwide?

MS. HILTON: In Texas' view, it can only be--you know, it can't be set aside piecemeal.

And then secondly, Your Honor, I think this is an appropriate case for there to be a nationwide injunction, because, in light of the Supreme Court's decision in *Dobbs*, we're turning the issue of abortion regulation and prohibition to the states. The fact that the federal government is sort of getting back in the game in this way to stipulate when an abortion is necessary or required flies in the face of that precedent.

And so for those two reasons, Texas thinks that this would be an appropriate situation to issue a nationwide injunction.

THE COURT: Okay. Let me follow up on that. So it was either today or yesterday, the Fifth Circuit issued a published opinion written by Judge Higginbotham, who I know something about, who reversed--it was a Louisiana injunction for a lack of clarity, exactly what-- It was about, I think, an oil lease. I'm not asking you to be familiar with that case, because it came out, I think, this morning. But clarity is required for an injunction. This was a nationwide

injunction. It got reversed because it just wasn't specific enough.

Exactly what do you want? I understand the--if there's a violation of the administrative procedure after the Medicare Act's requirements of notice and comment, set it aside. It's either a validly issued guidance or it's not. I can understand that, so you won nationwide.

The second piece, though, if I think that their view of the law is beyond the scope of the statute and that it just goes too far, are you asking me to enjoin the agency's understanding of the law and that they can't enforce it in that way, or just--because the letter will be gone. They can still--I mean, they--you know, parties can file whatever they want. I see that every day in my court. What exactly do you want on the second piece?

MS. HILTON: Texas would be asking the Court to enjoin the enforcement of this rule and to set it aside, to--and, you know, then the defendants could remedy their procedural issues, if they wanted, through notice and comment and et cetera. That would--and--yes, enforcement--yeah, setting it aside and prohibiting enforcement of the terms of this guidance, that the defendants couldn't threaten civil or--penalties to physicians for failing to comply with this guidance, or termination of CMS provider agreements for failure to comply with this guidance, all--

THE COURT: So you want me to say you can't bring enforcement actions; you can't fine people; you can't pull funding if the violations that you suspect are from this letter?

MS. HILTON: Yes, Your Honor.

THE COURT: Or this memo?

MS. HILTON: Yes, Your Honor.

THE COURT: If they brought a lawsuit that said, "No, no, no, we're not--it doesn't stem from the guidance and letter; it stems from just the statute itself, and that's our view," would that be enjoined?

MS. HILTON: Yes, Your Honor. Yes.

THE COURT: All right. Let me ask one more question; then I'll hear from Mr. Eldred. And, Mr. Healy, I promise I'm going to give you this time. This is a common occurrence in my court, and I can't help myself.

Redressability. If I give you that, how is your injury redressed? They've issued this letter. They say it's just an illustration, just an example, friendly reminder. I say, nope, you violated notice and comment, and you're beyond statute; stop.

How does that redress your injury?

MS. HILTON: Your Honor, Texas doesn't need to wait--under Fifth Circuit precedent, I don't believe that Texas or any of its hospitals or physicians needs to wait for the

federal government to drop the hammer and pursue a-hundred-and-twenty--almost $120,000 in civil penalties against both hospitals and physicians. I think this is ripe for preenforcement review now.

Does that answer--am I answering the Court's question?

THE COURT: I think so. Yeah, it was a redressability question. So how does your injury go away if I tell them--tell everybody that this letter was invalidly issued and you're enjoined from enforcing it in any action?

MS. HILTON: Well, Texas will--

THE COURT: Because then just the threat goes away, I guess.

MS. HILTON: Yes, I mean, the threat goes away, but also, Texas will be allowed to enforce or it can enforce--is not pressured to change its laws--can enforce its own legal code that its citizens have--you know, their representatives have passed. So--and that injury to Texas' law is ongoing, and so that's--the Court setting that aside and enjoining it would remove the threat to Texas law.

THE COURT: What if I only set it aside? What if I said, I'm not comfortable with your argument on--that it exceeds statutory authority; I just want to decide a notice-and-comment violation, and that were the only grounds? Would your injury be redressed then?

MS. HILTON: I don't believe so, Your Honor, for the reason that you articulated, that if the federal government were to say, well, no, we're--you know, it stems from EMTALA and not from the guidance. I think they would have to be enjoined from issuing this threat.

THE COURT: Okay. All right. Anything else? I know that you've reserved ten minutes. Thank you for your patience with my many, many questions.

MS. HILTON: Thank you, Your Honor.

THE COURT: Okay. Give me one second so I can make sure I mark the time.

All right. Believe it or not, Ms. Hilton, that was 40 minutes, so I'll ask my law clerk to keep track.

All right. You have ten minutes to argue the Constitutional arguments; is that right?

MR. ELDRED: Yes, Your Honor. I might be quick and I might not need all ten minutes.

THE COURT: Go ahead.

MR. ELDRED: I want to talk about the spending power issue. The guidance is not a valid exercise of Congress's authority to spend money and attach conditions to the spending of the money. Of course, under the law, Congress must give clear notice of all these conditions, and for the reasons that Ms. Hilton was just talking about, that did not happen. The EMTALA statute does not require the guidance. The

guidance is contrary to the EMTALA statute. So consequently, the EMTALA statute does not put Texas on clear notice that, by taking Medicare funds--or also by hospitals and physicians--by taking Medicare funds, that they are required to comply with this guidance.

And that argument mostly dovetails with what Ms. Hilton was talking about. Your Question Number 3 asks if this is a question of law. The answer, I think, is yes. The *Pennhurst* case says that Congress must put the recipient of funds on clear notice, which means it has to be in a statute, and statutory construction is something that judges do, and this is questions of law.

THE COURT: Okay. So the fact that I have all these declarations from amici or from the United States itself that says, "This is how we've always understood EMTALA; what's everybody talking about," that evidence is just irrelevant to my analysis, in your view, because it's a question of law.

MR. ELDRED: Yes.

THE COURT: Is that fair? I'm not trying to put words in your mouth; I'm just trying to understand what each side thinks are the variables in my calculus.

MR. ELDRED: I think that's true. The precedent is, Congress must give clear notice. I don't know how that's possible without--except through a statute.

THE COURT: Okay. All right. I understand.

MR. ELDRED: So I don't want to dwell on that. The arguments overlap with the other arguments. This is outside their statutory authority; therefore, there is no clear notice.

And if the statute does somehow allow them to do this, even though the statute doesn't seem to say that, that would be a nondelegation problem. I don't think I need to say a whole lot about that, but I'll be happy to answer questions.

The one thing that the spending clause argument does add here is the coercion element. Under the precedent, Congress may not use spending power to coerce states into accepting money. And the coercion in this case is--I think the defendants agree, is 42 U.S.C. 1396c, which says, if you don't comply with all the Medicare statutes, you can lose all your money or some of your money.

They cited a case that said that that's not a coercion under a Fourth Circuit case from 2002, but the *Sebelius* case in 2012, the Obamacare case, I think said the opposite, that it was a coercive use of the spending clause power. And in that case, the requirement that states accept--expand Medicare or lose all their funding or be--possibly lose all or some of their funding was found to be a violation of spending clause power.

I think we have the same situation here, and I think the defendants agree. If Texas refuses to do what--refuses to comply with EMTALA, they are subject to losing all

or some of the funding. So that's another thing--another reason why we should win this case.

THE COURT: Okay. So spending clause violation because it's coercive, I think. Correct?

MR. ELDRED: Coercive and no clear notice.

THE COURT: And--yeah, and that it's ambiguous. There's no clear notice of this, as required by--I guess *Pennhurst* would probably be your best authority?

MR. ELDRED: Yes, Your Honor.

THE COURT: Okay.

MR. ELDRED: *Sebelius* says the same thing.

THE COURT: Thank you. All right. And *Sebelius*. All right.

Although it is, in your view, a question of law, are you aware or do you have any evidence of hospitals in Texas or elsewhere, I guess, that previously have not provided abortions--they either are Catholic hospitals, they're Baptist hospitals, they're fill-in-the-blank, or maybe they're a rural hospital and they just don't have the items necessary for it--that will now, in the United States's view, be required to provide abortions, and they object to that in some way?

MR. ELDRED: I think I've got two answers. First, I don't think they have anything like that in the record, so I think the answer has to be no there. But I think that brings up possible RFRA issues that Mr. Bangert is going to discuss.

THE COURT: Okay. All right.

MR. ELDRED: If he's not, I apologize. I think that may be part of his presentation.

THE COURT: Okay. I understand. All right. Thank you. Anything else?

MR. ELDRED: Just we make a Tenth Amendment argument. The courts call the coercion problem a Tenth Amendment problem, so it's a Tenth Amendment problem. And then, of course, Congress cannot act unless it has enumerated power, so if it's somehow allowed to do this even though there's no power allowing it to do that, that's also a Tenth Amendment violation.

Like I said, the Constitutional arguments have a lot of overlap except for the coercion angle, but we think they are just as important.

And unless you have any questions, I think I'm done.

THE COURT: Are you arguing that-- And if this question is better for Ms. Hilton, she can address it in rebuttal. But are you arguing that the federal government is never allowed or permitted to regulate abortion?

MR. ELDRED: I think that says it--I think that's overstating it. No.

THE COURT: Okay. That's an overstatement. If EMTALA were amended, I guess, next year, or this year,

whenever, to put in the provisions of the guidance and letter that are there now, permissible?

MR. ELDRED: That, I think, is a whole nother case. Maybe. That might be the one case that gets people to reevaluate spending clause power. That would be a huge political angle, I think. That would be--that would be massive. That's not going to happen--you know--

THE COURT: Yeah, it's a hypothetical. I'm not saying it's likely. I don't think it is--

MR. ELDRED: Maybe.

THE COURT: --at least imminently, but--

MR. ELDRED: I don't know if Texas and other states would roll over and say, oh, well, we--I guess we have to--I guess we have to have abortion because we want our Medicaid money. I think we may--there may be a fight about that.

THE COURT: Based on spending clause?

MR. ELDRED: Yes, Your Honor.

THE COURT: Okay. I understand that, however many years ago--

MR. ELDRED: I think there was a fight about that in *Sebelius* actually.

THE COURT: I'm sorry?

MR. ELDRED: In *Sebelius*, some of the states said, no, we're not going to expand our Medicaid; we don't want--and you can't make us do that.

I think we might have the same similar fight if that were to happen--if EMTALA were to somehow be amended to add in the guidance. I think that's where we would be. I think the hypothetical is probably too far afield for this hearing.

THE COURT: But as-- Well, I'm the one that gets to ask the hypotheticals. That's the--

MR. ELDRED: I didn't mean to put it that way. I'm sorry, Your Honor.

THE COURT: Yeah. No, that's okay. I know you didn't. I know you didn't.

MR. ELDRED: I meant to say I'm not prepared to talk about that right now.

THE COURT: Yeah. No, I get it. You all will have the benefit of the doubt with me.

But in your view, currently, EMTALA never envisioned abortions in its language. Correct?

MR. ELDRED: It doesn't put you on--it doesn't put anybody on clear notice that it's a pro-abortion statute. It came out in '86. Right? It was adopted in '86, in the--under the Roe vs. Wade regime. I don't even know if anyone even thought about it back then.

THE COURT: Okay. And to the extent a doctor is required to stabilize under the statute, it's only as derivative and informed by state law?

MR. ELDRED: I'm sorry. One more time?

THE COURT: To the extent a doctor is required to stabilize a patient through the performance of an abortion, the doctor is only allowed to do that by reference to state law? Or the scope of that ability is defined by state law?

MR. ELDRED: As EMTALA is written now, yes, under 1395 and under--

THE COURT: Okay. And I was about to ask you where in the statute it says that. So 1395, which says, we're not regulating the practice of medicine, essentially?

MR. ELDRED: Correct. And also--I believe Mr. Bangert is going to talk about this as well--other parts of federal law talk about abortion as well. There's the Hyde Amendment. There's many other laws that suggest that abortion is not something Medicaid pays for.

THE COURT: Okay. All right. Thank you.

MR. ELDRED: Thank you.

THE COURT: I appreciate your argument, Mr. Eldred.

All right. Mr. Bangert, am I right in remembering that you had 20 minutes?

MR. BANGERT: Yes, Your Honor, I believe that's correct, and I will try to be very efficient.

THE COURT: No problem.

MR. BANGERT: And also try to make sure I deliver on all the promises Mr. Eldred made about my presentation.

THE COURT: No problem. You have 20 minutes, and I'll give the United States back time. So no rush. We've gone over because of me, not because of anybody else.

Go ahead.

MR. BANGERT: Thank you, Your Honor. Ryan Bangert on behalf of American Association of Pro-Life Obstetricians & Gynecologists and Christian Medical & Dental Association.

I want to go right at the elephant-in-the-room question, which is, why does this guidance document--which we believe is a mandate--why does it matter to my clients? Why did they join this lawsuit? What's so important about it?

Defendants contend that this mandate merely restates what EMTALA has always required. Now, that's a curious claim to make, given that they now have 20 blue state AG's, several august medical bodies joining in as amicus curiae. It's very curious to me why something that doesn't matter has attracted so much attention.

And the reason is, it does matter. And I won't bury the lede for you, Your Honor. This is about recentering the abortion economy of the United States on chemical abortion. It's about recentering the America's abortion industry on Mifepristone to get around the restrictions that are being imposed by red states currently. How does that work?

I want to back up for a second. I don't want to lose the forest for the trees.

THE COURT: And before you do that--
MR. BANGERT: Yes, Your Honor.
THE COURT: --the word you said, say it again.
MR. BANGERT: Mifepristone.
THE COURT: Okay. So that's different than Methotrexate that is mentioned in the guidance and letter?
MR. BANGERT: Yes, Your Honor.
THE COURT: We're talking about two different things?
MR. BANGERT: Yes, Your Honor, we're talking about two different medications.
THE COURT: Okay. Methotrexate is common for multiple things, but for ectopic pregnancy, as I understand it. Is that right?
MR. BANGERT: It can be. I believe that's correct, Your Honor. I don't want to fully represent it. I'm not a physician. But Methotrexate is also a cancer medication. It can be used, in some instances, to assist with miscarriages, is my understanding.
Mifepristone has been approved by the FDA specifically for use to induce abortion up to ten weeks.
THE COURT: Okay. And I don't mean to put you on the spot, but for the sake of my court reporter, who is the most powerful person in the room because she's the only one that can tell me to shut up, will you spell that for her,

please.

MR. BANGERT: Yes, Your Honor. M-i-f-e-p-r-i-s-t-o-n-e, Mifepristone.

THE COURT: All right. And you were saying how it's recentering the abortion industry.

MR. BANGERT: It is, Your Honor. And I want to back up just for a second so that we don't lose the forest for the trees. This really all started on July 8th when President Biden issued Executive Order 14076 directing HHS--and this is in our briefing--to identify actions that, quote, would protect and expand access to abortion care, including medication abortion.

Now, medication abortion is a term of art. It means chemical abortion, Mifepristone abortion. That's what it means. So he's directing HHS to identify actions that would expand access to Mifepristone abortion.

Now, prior to July 8th, the federal government had already taken steps to do that. And how had they done that? By revising the REMS, the Risk Evaluation and Mitigation Strategy document that FDA applies to Mifepristone. REMS are applied to drugs that are dangerous. Mifepristone is recognized as a dangerous drug. It's a deadly drug. It kills unborn children.

FDA has long applied a REMS that requires Mifepristone to be dispensed only in the presence of a

physician. And there are good reasons for that, because they need to be assessed and evaluated for the length and terms of pregnancy, whether they have ectopic pregnancies.

That requirement was suspended on April 12, 2021, in response to the COVID pandemic by President Biden. That was made permanent December 16th, 2021. And if you read the documents around that, which are all up on the FDA's website, they talk about the fact that this facilitates mail-order abortions. So now we have a mail-order abortion economy.

President Biden then interjects on July 8th, 2022, and says, we're going to--I'm directing HHS to take further steps to expand access to abortion care, including medication abortion. On July 13th, drops the pharmacy guidelines and the pharmacy mandate which requires a pharmacy not to discriminate against pregnant women in their ability to access reproductive health care, and it specifically calls out Mifepristone.

That brings us to Attorney General Garland's statement on August 3rd, where he says, "Since"--I'm quoting from his statement, which is on the DOJ website--"Since the day that *Dobbs* was decided, the Justice Department has made clear that we will be relentless in our efforts to protect and advance reproductive freedom." And he adds, "States may not ban Mifepristone based on disagreement with the FDA's expert judgment."

That brings us to the EMTALA guidance that we have

in front of us today. How does the EMTALA guidance fit within this effort, this full-court-press effort by the federal government to recenter America's economy--abortion economy on Mifepristone. Here's how. Because Mifepristone creates complications. Complications create the need for emergency access care. EMTALA is the statute that governs emergency care in the emergency room. They need to make sure that these women who are going to be experiencing the complications of Mifepristone abortion have access to doctors who can help them facilitate the completion of those abortions, which is why the guidance document specifically calls out incomplete medical abortions. Medical abortions, Mifepristone abortions.

Why does this matter? How does this affect my clients? My clients are pro-life organizations that represent the interests of physicians who object to performing elective abortions.

THE COURT: Let me jump in--

MR. BANGERT: Yes, Your Honor.

THE COURT: --just to make sure I understand the kind of table dressing that you just set up. Guidance, regulations, including FDA regs--REMS, you called them--have been rolled back to allow additional access to this chemical. People can now get it mail-order. They take it--is that--today, they can get it? I can--

MR. BANGERT: They can receive--

THE COURT: --I can order this; it comes to me; I can take it. And previously, it had to be in the care of--or in the presence of a physician, in the care of a physician?

MR. BANGERT: It had to be dispensed within the presence of a physician.

THE COURT: Okay. No longer. So you take this. That begins an abortion. Then someone goes to the doctor and says, look at this letter. I've started an abortion; this letter now requires you to finish it for me.

MR. BANGERT: Almost, Your Honor. Actually there's a second regime, a drug that is part of the Mifepristone regime called Misoprostol. Once the baby is killed by Mifepristone-- It cuts off the nutrients to the baby. The baby dies. Misoprostol is then taken to induce labor, and the dead fetus or the dead baby is expelled.

THE COURT: Okay.

MR. BANGERT: So it doesn't actually--you never have to actually go to a doctor unless there are complications--

THE COURT: I see.

MR. BANGERT: --which arise frequently. Which arise frequently. In fact, if you look at the declarations of the defendants' own experts, they talk about these complications; bleeding, hemorrhaging, all the things that can happen. And so it is a situation where it's not a safe drug.

That's why REMS were applied years ago.

So how does this--why does this matter to my clients? Here's why. Because EMTALA, as it's designed, absent the mandate, is a statute that does not permit elective abortions. How do we know that? Because the statute--first off, it doesn't contain the word "abortion" anywhere in the statute. An abortion-- You asked--one of the questions you asked was, how do you define abortion. One of the ways you can define it is in the Federal Code, which is--I believe it is the CFR's. I apologize, Your Honor. I'm going to have to locate this in my notes, because I have now moved around a little bit.

THE COURT: Okay.

MR. BANGERT: The CFR's, 45 CFR 283.2, which is in the Social Security Act, which is the Act in which EMTALA, I believe, is located. It says that abortion is defined as, quote, induced pregnancy terminations, including both medically--Mifepristone--and surgically-induced pregnancy terminations.

So abortion encompasses both medical--which are drug-based, Mifepristone-based--and surgical, which are the ones that people often think of when they think of abortion clinics. So that's how the federal government defines abortion. It's--never once has the word "abortion" been--and even today, not included in the EMTALA statute.

EMTALA does, though, provide us with some guardrails on how to handle situations that have been raised ad nauseam in the declarations, situations like ectopic pregnancies, situations like miscarriages with complications, like hypertension with severe features, and all of the other things that are listed in the declarations.

And by the way, my clients, when they looked at those declarations, they said, yep, yep, yep, most of those are situations that we believe threaten the life of the mother; we would actually perform a separation of the mother from the child. We will not perform elective abortions. What does that mean to my clients? It's in their declarations. They will not perform an abortion with the intent to kill the child. Rather, they will only terminate a pregnancy to save the life of the mother. And under the Catholic doctrine of double effect, they believe that is morally acceptable--most of my clients are Catholics--method acceptable, ethical distinction.

So how does that get us to the statute? The statute specifically defines emergency medical conditions, which are the trigger for providing stabilizing care. "Emergency medical condition" is defined in the statute as a condition of sufficient severity, the absence of medical attention could reasonably be expected to result in placing the health of the individual--and this is important. This is--I'm quoting 42 U.S.C. 1395dd(e)(1)(A)--

THE COURT: I have it in front of me.

MR. BANGERT: --placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child.

The statute requires physicians, when evaluating how to stabilize emergency medical conditions, to consider the interest of the woman and the child together. The duties run to both. When the duties run to both, you cannot perform an elective abortion, because you would be--you would be--you would be killing the child without the need to preserve the health of the mother. That is precluded by that language in the statute. Elective abortions are out.

Now, there are situations where those two are in tension. You cannot preserve the health of the mother and the unborn child. In those tragic situations, the option goes to the mother. She can sign informed consent; yes, terminate the pregnancy. That is not an intentional abortion with the intent to kill the child. That is not precluded under my clients' ethical system. They don't object to that. In fact, they will perform those procedures. Ectopic pregnancies, many of the things we've talked about today, that is not objectionable to them. What is objectionable, though, is being forced to perform an abortion that is not necessary to save the health and the life of the mother.

The guidance document reverses the polarity. The

government has adjusted the dials in EMTALA by changing subtle things in the guidance document that create a situation where, in certain circumstances, my clients could be forced to perform elective abortions.

Now, I want to very quickly, Your Honor--I know our time is short. I want to quickly walk you through how that could happen specifically.

THE COURT: Yeah, you have twelve minutes left in your twenty minutes, so go ahead.

MR. BANGERT: Very good, Your Honor.

So, Your Honor, the first thing that happens--the first thing that the guidance document does that departs from the statute is, it expressly identifies abortion as a form of mandatory stabilizing care. And abortion, as we've seen in the Federal--even in the Federal Code, is defined as, including elective abortions; medical abortions, surgical abortions. It includes elective abortions.

Now, the government will say no, no, no, it doesn't require elective abortions, because you have to have an emergency medical condition in order to trigger the requirement. Right? But the problem is, they monkey with the definition of EMC, emergency medical condition, too. How do they monkey with that definition? Well, as has already been mentioned by my colleague, Ms. Hilton, EMTALA defines--and as I pointed out, it defines EMC, in the context of a pregnant

woman, to include a severe risk to both the woman and her unborn child. The duties run to both. Right?

Well, the problem with the mandate--the problem with the mandate is, it drops the reference to the unborn child. That eliminates the duties that run to the unborn child. It eliminates that obligation to counterpoise the two against each other.

THE COURT: And what if they say, well, the only reason it does that is because this document--assuming this is going to be their argument. I'm not sure that it is. But if they argue, the reason that is dropped is because the document is truly focused on only those tragic situations that you described, where it's mom or baby, what's your response to that?

MR. BANGERT: Well, they're--

THE COURT: So it's okay that they would drop it, because necessarily, if we're only talking about those tragic situations, we all know what's going to happen, and it's tragic but necessary.

MR. BANGERT: Well, they're also--they're talking about how to treat emergencies in the context of pregnancy, so it's a very curious thing to drop from a guidance document that's expressly addressing the specific statutory language, addressing pregnant--emergencies in pregnancy situations. And I think something they do in their briefing gives the lie to

that potential--I'll put a pin in that, because something they do later in their briefing really, I think, exposes what's going on here. So I'm going to get to that in just a moment.

THE COURT: Okay.

MR. BANGERT: So you have this situation where they've inserted abortion, which includes elective abortions. They have dropped any reference to the unborn child with respect to nonlabor situations. And then the next thing they do is, they add a list of examples of emergency medical conditions. And they list ectopic pregnancy, fine; complications of pregnancy loss--not even abortion, because the baby is already dead. Emergent hypertensive disorders--sometimes that can be serious enough to require a separation. But then at the end, on page 6, they call out incomplete medical abortion. They just throw it in there, incomplete medical abortion. Here's another emergency medical condition that might require abortion.

They say not to worry, not to worry again. Because if you look at their experts, they say, look, a failed Mifepristone abortion is not always an emergency medical condition. It's a failed Mifepristone abortion, one that didn't work. But if you look at Dr. Haider, she talks about an ongoing medical abortion in her declaration. On pages appendix 24, and again on page 27, she notes that in the instances of ongoing medical Mifepristone-based abortions, you

could have women present to the emergency room in distress with still-detectable fetal cardiac activity. The baby is still alive. What do you do in those situations? What do you do?

Well, here's where the rubber really meets the road for my clients, and this is why they are so concerned about the guidance document, which we believe is a mandate. I believe that the document requires abortion in that circumstance, even if the baby can still be saved without jeopardizing the life of the mother.

THE COURT: Okay. Where is that in the document?

MR. BANGERT: Here's how you get there. Because the document says-- We put this--we actually put a tea leaf out, and this is the footnote that I mentioned to you earlier. We put this out sort of as an offering. We talked about Progesterone, abortion pill reversal therapy. All right? If you have a woman presenting with an ongoing Mifepristone-induced but still incomplete medical abortion, fetal cardiac activity is still present, meaning the baby is still alive, but the baby is in distress--in fact, one of the cases that's cited by the government, which was *Planned Parenthood of Tennessee vs. Slatery,* in Footnote 3, they really trash on what they call abortion pill reversal, which is Progesterone therapy. They say--in fact, what they say in their footnote is, it's never appropriate, ever appropriate. You can never use this. They have completely taken it off the

table. You can never use that therapy. It's always wrong to do so.

Well, in that case that they cited, though, there's a lot of expert testimony discussed. And one of the doctors noted that if a woman takes Mifepristone and does nothing else, there's only a 25 percent chance the baby is going to live. And what happens is, that baby dies in utero, and without Misoprostol, that creates, oftentimes, an emergency situation where there is now a miscarriage, an induced miscarriage with retained fetal matter, that's an emergency. Right?

So you have a woman presenting. She's in distress. She has taken Mifepristone. The baby is still alive. The doctor says, I would like to go ahead and administer Progesterone to save the life of the baby. The mother is not yet in a position where she is hemorrhaging substantially. Her life is fine. We can save the baby and the mother.

The government says, no, you can't. Absolutely not. You cannot administer Progesterone. That's absolutely forbidden. It's off the table. Footnote 3 is off the table.

Well, do you have an emergency medical condition in those circumstances? Yeah. Because 75 percent of those cases where Mifepristone has been administered, if you do nothing else, 75 percent of those cases, according to the case I just cited you, the fetus dies in utero, and that creates a--that creates a miscarriage with retained fetal matter, which could

lead to an emergency condition.

And that's why the language that Ms. Hilton cited is so important. If it's likely--if a condition is not yet immediately emergent, if it is not yet immediately critical but is likely to become emergent--this is on the first page of the guideline--that counts as an EMC. Right? So you have a baby who is in distress, a woman who presents who you can save them both. Nope, you can't use Progesterone; you've got to sit and wait and see what happens. Most of the time, that baby is going to die, creating an EMC. You've got to treat that on the spot. And the only treatment left, as far as I know, is abortion. You have to complete the abortion. You have to--you have to either use surgical or chemical means, Misoprostol, to get that dying baby out of that mother's body. And this is always taking place before viability.

THE COURT: So the only treatments are either an abortion or Progesterone?

MR. BANGERT: I am not aware, Your Honor, of any other treatments.

THE COURT: Okay. And according to the document and then as revealed by Footnote 3, their discussion of the document, Progesterone, not permissible.

MR. BANGERT: In fact, they put the word--I believe the word "never" in italics.

THE COURT: Does it matter that it's in their brief

and not in the guidance?

MR. BANGERT: I don't believe so, Your Honor, because I think they're taking a position in this court as to what their document means.

THE COURT: Okay. All right. You do have--you have four minutes left. Was that kind of the completion of the primary point? I wanted to let you finish that, but then I do have questions.

MR. BANGERT: Yes, Your Honor, I think that really gets to it. Basically you have a situation where, when you have incomplete medical abortions where the woman and the baby can both still be saved, the way that they have monkeyed with the guidance creates a situation where they have taken lifesaving care off the table for the unborn child and they are driving doctors toward abortion.

And if you don't-- And by the way, the guidance says you have to offer all available stabilizing care options to a woman, and then she gets to pick. Well, if you've taken Progesterone off the table, you're going to put abortion on the table, and if she picks it, you've got to do it or, guess what you've done. You've dumped her.

THE COURT: Okay. All right. Let's talk about standing. You have a few declarations from your members; I think a senior vice-president and one member. The explanation you just gave to me, the argument you just provided, it's not

in the declarations, is it? Or is it?

MR. BANGERT: Your Honor, it is, but it's not in that level of detail.

THE COURT: Okay.

MR. BANGERT: It's--and I'd like to point you to the declaration of Donna Harrison, paragraph 15, appendix page 018: For example, the abortion mandate requires performing essentially an elective abortion where women present to an emergency room having previously initiated medication abortions, Mifepristone abortions, where the unborn child is still living and may still be preserved.

So that is the basis of their objection.

THE COURT: Okay. I see.

MR. BANGERT: And I just compact it better than we did in the declaration.

THE COURT: Okay. I understand. All right. So it's, in your view, encompassed within that statement, paragraph 15 of Harrison's declaration. The United States has objected, saying their language is just too ephemeral, nonimminent to provide standing. They say these things could happen and that's just--that doesn't get you over the finish line for standing.

I think in the reply brief that was filed two minutes after midnight--a paralegal's--

MR. BANGERT: We apologize.

THE COURT: --a paralegal's nightmare. Please tell whoever did that that I'm not upset.

So I haven't had long with that, but I think your reply was, well, just being--I can't remember if it was coercion or a different word, but just being pressured to--

MR. BANGERT: Pressured. Yes, Your Honor, the word is pressured.

THE COURT: --yeah--to alter our behavior is sufficient for-- Is that your argument? Is your argument that, all right, that it could happen in the future, maybe that's not enough, but the--that's not the standard. The standard is, do they feel pressure to change their behavior in violation of their sincerely-held religious beliefs? Of course, this is pressure; we have standing; see X, Y, and Z. Is that it?

MR. BANGERT: Well, Your Honor, I think we have two different arguments going here. One is the APA, the notice-and-comment question. And certainly we were not given any opportunity to raise these objections through comment, because they never put it out for notice and comment.

THE COURT: And so that would be procedural injury, and so standing to challenge the notice and comment?

MR. BANGERT: Yes, Your Honor.

THE COURT: Okay.

MR. BANGERT: So I believe we clearly have standing

on that ground, because this actually affects our concrete interests in a direct way, because it would impose upon our doctors an obligation to perform elective abortions to which they clearly object, in their declarations, that they will not perform under their religious beliefs, and if they do not perform them, they are subject to immediate penalties. They are the object of the regulation. They are the object of the statute. They are directly regulated by EMTALA. Emergency room physicians, of which our declarations clearly point out several members of both organizations are both OB/GYNs and/or emergency room physicians. We have submitted three declarations on behalf of individual physicians. All of them are subject to EMTALA and have practiced successfully under EMTALA up until now that the guidance document was issued.

But I also want to point out it's very likely that these kinds of situations will arise frequently. If you look at the amicus brief that was filed by the Medical and Public Health Societies in opposition to our motion, on page 6 and page 7, they point out that--they point out--I'm sorry, page 7 and page 8: pregnant women regularly seek emergency care, and that care sometimes involves treatment that can be characterized as abortion. In virtually every shift, and often multiple times a shift, emergency practitioners see pregnant patients presenting with abdominal pain, vaginal bleeding, or other pregnancy-related issues. While most do not require

intervention, emergencies involving pregnant patients are frequent and dangerous.

This is coming right from these eminent medical associations, including ACOG and others.

THE COURT: So their own declarations show that this happens all the time--

MR. BANGERT: This is very frequent, yes.

THE COURT: Okay.

MR. BANGERT: And so you're going to have these-- And, plus, you add that to the fact that we're now moving on to a Mifepristone-centered abortion economy. It's going to happen even more frequently than it has before.

But, Your Honor, I think that our procedural injury is very clear here, because we did not have any opportunity to raise these objections and to point these things out before the mandate was released. And, clearly, it affects the concrete interest, because our doctors are in those emergency rooms today, and at any moment, probably actually multiple times a shift, they're going to see women who may be facing this situation. In fact, the vast majority of abortions that are performed even today in the United States are Mifepristone-based abortions. It's over 50 percent. I say "vast." It's over 50 percent, so--

THE COURT: Okay. Your procedural injury is clear in your view. The direct injury is, this happens all the time;

they are on the front lines; see their own--see the United States' own declarations; and we're pressured.

What's your best case for the pressure? Pressure is the guiding standard for RFRA standing?

MR. BANGERT: *Sherbert vs. Verner*.

THE COURT: *Sherbert*, you said?

MR. BANGERT: *Sherbert vs. Verner*. We cite that in our reply brief, Your Honor. But we also cite to *Texas vs. EEOC*, several cases out of the Eastern District of Texas that have talked about pressure in the context of an APA procedural injury, is certainly sufficient.

And here, we are clearly being pressured by this mandate to conform our conduct to what it requires and that is likely to arise multiple times a shift, in fact, to encounter women who are experiencing emergency medical conditions, especially those who are pregnant. So I think it's very, very clear, especially under the APA, that we have standing to raise these claims.

THE COURT: Okay. You're two minutes over, but I've interrupted you a lot. Were there any other points that you wanted to make?

MR. BANGERT: Your Honor, I just wanted to also address the very last question that you asked, which is the scope of relief.

THE COURT: Yes, please.

MR. BANGERT: With respect to that, Your Honor, we represent two private parties. We believe that an appropriate form of preliminary relief at this point would simply be an injunction that runs only to our individual--only to our organizations, which would cover the membership of those organizations. We have received injunctions like that from North Dakota, from other places. And typically the way they're fashioned is, the injunction runs to the benefit of the organization and its members, since we're representing them in an associational capacity, so the membership of our organization can take advantage of the injunction, so--

THE COURT: I understand.

MR. BANGERT: That's--but we're not asking for nationwide relief.

THE COURT: Okay. So an injunction that stops enforcement of EMTALA as determined by this guidance and letter, or mandate as you call it, as to your organizations and your--and those--and the members of those organizations?

MR. BANGERT: That's correct, Your Honor. And--

THE COURT: Remind me. Did you-- I'm sorry. Go ahead.

MR. BANGERT: Please.

THE COURT: Did you cite the examples of where those injunctions have occurred in either your briefs or your reply? I can't recall.

MR. BANGERT: I believe that--

THE COURT: I would like to look at--

MR. BANGERT: I apologize, Your Honor. I will--I believe we did cite to several of the cases that we have litigated recently. They were in the RFRA context. But *Christian Employers Alliance vs. EEOC* on page 25 of the reply, 22 WL 1573689, D.N.D. out of North Dakota. The *Religious Sisters of Mercy* case *vs. Azar*, that was actually a Becket Fund case, very similar type of issues. Those dealt with EEOC guidance documents. That dealt with SOGI issues, sexual orientation/gender identity issues. But the relief that was granted was limited to the parties.

THE COURT: Okay. All right. Thank you, Mr. Bangert.

MR. BANGERT: Yes, Your Honor.

THE COURT: All right. It is 2:25, and so--2:24. We'll call it 25. So we went for an hour and fifteen minutes, so you'll have, to the extent you need it, an hour and fifteen minutes.

We've been going for an hour and fifteen minutes, so why we don't take just a brief comfort break for the sake of everyone in the room but, most importantly, my court reporter. So we will take a 10-minute break. We'll be in recess until 2:35, at which time, Mr. Healy, you will make your argument. You will have no more than an hour and fifteen minutes.

And then how long was reserved for rebuttal?

MS. HILTON: Ten minutes, Your Honor.

THE COURT: Ten minutes? Okay. And up to ten minutes for rebuttal.

We are in recess.

(RECESS TAKEN)

THE COURT: All right. Mr. Healy, at the podium, please.

I told everyone earlier I was not good at math, and I'm not, at least off the top of my head.

MR. HEALY: Pardon me? I didn't hear that.

THE COURT: I said I told everyone earlier--I warned everyone earlier that I'm not good at math, at least off the top of my head. I told you you had an hour and fifteen minutes, which was time that was just spent. There's also ten minutes for rebuttal.

MR. HEALY: That's fine.

THE COURT: So to the extent you need it, you also have an hour--you have an hour and twenty-five minutes, not an hour and fifteen minutes. That accounts for the rebuttal time.

Go ahead, Mr. Healy.

MR. HEALY: I think it will be sufficient, Your Honor.

Your Honor, the whole point of EMTALA is to ensure that covered hospitals offer appropriate emergency care to

patients, no matter who they are, no matter what types of emergency conditions they present with, and no matter whether or not they have insurance.

Plaintiffs read the statute to impliedly carve out abortion care from those important protections. In essence, they read the statute to allow hospitals to let pregnant patients suffer predictable consequences that are life-threatening that termination of pregnancy would reasonably be necessary to prevent. They do not deny or rebut Defendants' ample material that pregnancy is often--is sometimes, at least, proper treatment for certain emergency conditions. In fact, I just heard Mr. Bangert concede that fact.

Moreover, Plaintiffs' claims appear to rise and fall on a patent misreading of the guidance, that is, that the guidance allows for and requires the provision of elective abortions. As EMTALA's text reflects, and the guidance does, there is no exception to providing stabilizing care when that is the necessary care that is reasonable to treat an emergency medical condition. It's hard to even understand why they think an abortion mandate exists here.

I'm happy to address the arguments in whatever order you wish, but I can start with standing, if you prefer.

THE COURT: That's all you have to say to me. Let's talk about your definition of abortion, the threshold questions, the same ones that I asked the State of Texas. How

do you define abortion? It's not defined in the guidance memo. It's not mentioned in EMTALA. How do you define it? Because the guidance talks--I mean, the memo is addressed to--I mean, it's about abortion. Fair? The guidance and letter? I mean, it's about--

MR. HEALY: The guidance is a reminder to hospitals of the requirements of EMTALA, including as applied to the example of abortion care.

THE COURT: Yeah, and the focus of the--I mean, I'm not trying to trick you. The focus of the guidance and letter is about abortions. Stabilizing treatment. If the stabilizing treatment is abortion, you have to provide an abortion, even if state law requires otherwise. I mean, that's why this letter is issued, because, post-*Dobbs*, we have some states that don't allow it; some states do. This is phrased as a reminder that, oh, don't forget about EMTALA. Sometimes stabilization will be an abortion. You have to do it if you find EMC, stabilization is abortion, has to be an abortion. That's the thrust of the letter. Did I miss something?

MR. HEALY: Your Honor, I mean, the term "abortion" appears throughout the U.S. Code. As I understand the guidance to use the term, the term refers to an induced termination of a pregnancy. When the guidance refers to abortion, that's what it means.

THE COURT: Okay. Where do you get that? An

induced termination of a pregnancy. I mean, is it-- Okay. Help me understand your authority for that definition, because it's a fairly--

MR. HEALY: The authority for that definition is--

THE COURT: --it's a fairly-- Let's just go one at a time for my court reporter's sake. It's a fairly broad definition, and I don't find that broad of a definition in the U.S. Code or anywhere else. So help me understand where that comes from in the guidance and letter.

MR. HEALY: So what the guidance does is remind hospitals that when the proper emergency medical care for--the proper stabilizing care for an emergency medical condition is an abortion--that is, an induced termination of pregnancy--the hospital must offer that care. And, of course, the patient can--

THE COURT: Yeah, I understand that. I was asking for the authority for that definition. Just, where do you get that definition?

MR. HEALY: I don't--I think the authority for it is--it's merely the way the term is used in the guidance. I don't think that there--

THE COURT: Does it encompass and require an intervention performed by a licensed physician?

MR. HEALY: The statute requires that.

THE COURT: I'm asking HHS, via EMTALA, an

abortion, does it require--as the term is meant in the guidance and letter, which, in your view, is just a restatement of EMTALA, does it require an intervention performed by a licensed physician?

MR. HEALY: The term refers to--the guidance refers to care. The care that is required under EMTALA, of course, refers to licensed physicians. There are numerous words in the guidance document, Your Honor. Not all of them are defined. Many of them are not defined. And my point is merely that, because they use the term to refer to a certain thing, I don't think there needs to be particular authority to point to for the definition of that term.

THE COURT: A good friend of mine often says, clarity is more important than agreement. I'm just trying to get clear. That's it. Because the letter gets pretty particular and specific at times, including, like, ectopic pregnancies. And the State of Texas has carved out ectopic pregnancies, as well as some medical associations, from the idea of an abortion. Is treatment for an ectopic pregnancy an abortion, in your view--in the United States' view?

MR. HEALY: If it is an induced termination of pregnancy, which I think it is, then it would be comprised within the way that that term is used in the guidance.

THE COURT: Okay. Well, then--

MR. HEALY: But I-- Go ahead.

THE COURT: Now I'm confused, because, I mean, the CDC, which is part of HHS, defines abortion to include an intervention performed by a licensed physician intended to terminate an intrauterine pregnancy. An ectopic pregnancy is not intrauterine. It's either in the fallopian tube or it's outside of the womb, but it's not in the womb. And so, by the CDC's definition, that wouldn't be an abortion.

I'm just trying to understand the scope of what we're talking about, and what is the daylight between these two things. So I do think it's important to define-- What I'm hearing you say is, it's a word that's used; it's not defined; you don't have authority. That's okay. I will figure it out.

MR. HEALY: I disagree with that contention, Your Honor. I think--

THE COURT: Where is it defined?

MR. HEALY: I'm trying to provide the clarity. I'm providing the clarity right now. The way the term is used in the guidance is, induced termination of pregnancy. That's what it means. That's how it's used. If you read the guidance, I think it's clear that that's what they're referring to.

THE COURT: I've read it a million times. I'm asking for just the authority for it, and it's--you're just saying it is--it's HHS itself. It's just the way HHS is using it in the document itself.

MR. HEALY: I think there isn't--the term is used--

the purpose of using the term in the document is to remind doctors that when certain care needs to be provided as reasonably necessary medical treatment, that the doctors need to provide that care. And when that care includes the induced termination of a pregnancy, the induced termination of a pregnancy needs to be provided. That's what the guidance means.

THE COURT: Okay. Do you agree-- Let's shift to the potential areas of agreement. Do you agree that a tubal ectopic pregnancy, which is one of the examples listed in your brief and in the medical associations' brief, is immediately treatable in Texas?

MR. HEALY: I can't speak for Texas, Your Honor.

THE COURT: Well, you understand Texas' law, I assume, what we're talking about here. The whole fight is about whether your law or their law controls in these circumstances. They have represented that, no, a tubal ectopic pregnancy is excluded from our definition; that's not something we have to fight about, think about, hear. Do you agree with that?

MR. HEALY: I think that--

THE COURT: Or do you just not know?

MR. HEALY: It will depend on whether that particular tubal ectopic pregnancy were the reasonably necessary stabilizing treatment for a particular emergency

medical condition. I heard the State of Texas just say that tubal ectopic pregnancies are excluded from their definition of abortion, and so it appears that, in that instance, the requirements of EMTALA would apply.

THE COURT: Okay. What about miscarriage?

MR. HEALY: Miscarriage? I don't think a miscarriage is an induced termination of an abortion, so I don't think it's how that term has been used in the guidance document.

THE COURT: Okay. So when the medical associations' brief or your brief references miscarriage and treatment of miscarriage, that's not an abortion; that's not something that--they're concerned about something that is nonexistent here, in this fight anyway?

MR. HEALY: Well, I think it's somewhat complicated, Your Honor, because, as described in numerous declarations, there are also medical definitions of abortion, which I understand to include miscarriages, what we have commonly referred to as miscarriages. But I don't think a miscarriage would ever be an appropriate stabilizing treatment. It's something that happens. It's a condition that may present. But that's not how it would be referred to in the guidance. The guidance--

THE COURT: No, it's treatment of a miscarriage.

MR. HEALY: Treatment of a miscarriage?

THE COURT: Yeah.

MR. HEALY: It could be--

THE COURT: They're saying, not an abortion. Medical Association, who is your amicus, is saying, we're very worried; we're not going to be able to do this.

I'm trying to help narrow the fight. I think what we have here, in some degree, is a failure to communicate--

MR. HEALY: I understand--

THE COURT: --and that the concern maybe, in some instances, is unjustified, but--given the concessions that we have today, and I just wanted to see if I can clarify that with you.

But let's just move on. It sounds like-- So you wanted to talk about standing.

MR. HEALY: Sure. So Texas' theories of standing are several-fold, Your Honor. They begin with their potential sovereign injury. And I still, after hearing Ms. Hilton speak, haven't understood whether any actual termination of a pregnancy would fall within the gap between Texas' Human Life Protection Act and the definition of emergency medical care under EMTALA. It's--

THE COURT: You do agree that there's a gap between the two?

MR. HEALY: I agree that the wording of the statutes is different, but I--

THE COURT: Okay. Well, not different. You used the term that they haven't shown any abortions that would fall within the gap between emergency medical condition, or the memo's view of it, and Texas' law. I'm just trying to clarify, again. You agree that there's some daylight between those two, just based on the language?

MR. HEALY: I agree that there is a difference in the language, but I am--what was unclear to me and what I think is Texas' burden to demonstrate, which they haven't done here, is that any actual types of conditions would fall within that gap, because if there aren't any, then there isn't any sovereign injury here, Your Honor.

And as the declarations describe in a lot of detail, it's very hard to know where the line-drawing happens. Right? Doctors don't know, when someone shows up with preeclampsia, how quickly that will progress to eclampsia and how quickly that might result in seizures, ruptures of blood vessels that would pose threat to life.

So I understand, actually, Texas' argument to be somewhat even more extreme than maybe I had previously understood. Texas appears to now be arguing that abortion is entirely accepted, or--from the scope of emergency medical care under EMTALA. That is a very extreme argument, Your Honor. That would appear to suggest that state law, as I understand it, always provides the bounds of stabilizing treatment,

regardless of what actually would fall within the definition of proper stabilizing care for an emergency medical condition.

My colleague sitting over here, Your Honor, Mr. Ely, whose last name rhymes with mine, is from Massachusetts. And we were discussing that--you know, what if the State of Massachusetts passed a law that they are concerned about gang violence and gun violence, and they pass a law prohibiting emergency care for the treatment of gunshot wounds. If Plaintiffs' argument is correct, then state law governs, and no stabilizing treatment could ever be provided to suture wounds from gunshots.

That's a very, very extreme position, Your Honor, and it's not one, I think, that this Court should countenance.

THE COURT: Let's take the opposite end of that hypothetical-- Actually, let's finish the standing argument. Assuming that I think there is a notice-and-comment violation, just for the sake of argument, do you agree at least that there's procedural--there would be procedural standing under those circumstances, or do you also dispute that?

MR. HEALY: I think we dispute that, and I think it's a pleading failure, Your Honor. They haven't identified any facts that would suggest that they have any harm from a lack of notice and comment. I don't see that as any indicia of harm in their pleading or in their motion.

THE COURT: So even though you agree that there's a

gap between their exceptions and the definition of EMC and you agree, under this assumption anyway, that this guidance memo issued in violation of notice and comment, even under those circumstances, just no even basic procedural injury, because you don't think they're harmed?

MR. HEALY: Before I answer the question, I think I don't agree with the premise. I don't--

THE COURT: Under my hypothetical. The hypothetical here is, I have found there's a notice-and-comment violation. And we've talked about, there's some daylight. You think it's a purely academic daylight. But under those circumstances, you still say no procedural standing?

MR. HEALY: Yeah, I just want to make very clear that I don't think that we would concede that there is necessarily daylight between these two statutes. There may be or there may not be. But if the question is, had they pled injury from notice and comment, would there be standing, maybe. But that's not what is before the Court here.

THE COURT: Had they pled-- Say that again. Had they pled notice and comment?

MR. HEALY: They have pled notice and comment as a claim, but I think that's a separate question from whether they have pled it as an injury.

THE COURT: I see. Okay. All right.

And the next assumption is, if the Court were to

find that the guidance and memo were promulgated in excess of statutory authority--so not notice and comment, but just this goes beyond the plain language of the statute, or--and, for that matter, just in violation of the spending clause, another argument that they have pushed here today, under those circumstances, would you agree that there is standing?

MR. HEALY: I don't think I would, Your Honor, and I think the reason is, again, a failure to plead or anything. There's really nothing in the record that demonstrates that there's any injury to the State of Texas or to Texas hospitals or to any particular AAPLOG or CMDA members.

THE COURT: What about case law about sovereign interest?

MR. HEALY: Absolutely that it--had they met these burdens, perhaps there would be a sovereign interest, that-- If the question is, is there ever a sovereign interest, sure, in some circumstances. If there was preemption, there could be a sovereign interest implicated. But it's Texas' burden to demonstrate that one exists here, and that's simply not apparent on the face of the pleading.

THE COURT: So even if a court decides this is beyond the scope of the statute, it's unauthorized, it is broader than their state law and proposes to preempt it, that fact alone, in your mind, is not enough to provide standing?

MR. HEALY: Well, the standing is--

THE COURT: The getting in the way of their law, under this hypothetical, still not enough, in your view?

MR. HEALY: So the-- Standing is a threshold inquiry, Your Honor, so I feel like these questions have the issue backward. We can't assume that everything--that their misconception of the guidance is correct in order to demonstrate that they have standing. I think it's their burden to demonstrate that there is an actual injury and that this isn't just an abstract question of--

THE COURT: Yeah, I'm familiar with the basics of standing--

MR. HEALY: I understand.

THE COURT: --and I'm honestly not trying to trick you. I'm really just trying to understand different permutations. And I understand the instinct to not give an inch, but if that's the United States' position, that even under those circumstances, a state's sovereign interest wouldn't be infringed upon, I understand the argument.

Okay. What else would you like to talk about?

MR. HEALY: I disagree that that would be our position necessarily. My point is only that it's a failure to plead.

With respect to-- Do you have any further questions about the sovereign interest?

THE COURT: No.

MR. HEALY: Okay. With respect to their proprietary interest in hospital funding, Your Honor, they don't identify any doctor or hospital in all of Texas that suggests that a pregnancy termination is not sometimes a necessary stabilizing treatment for an emergency medical condition. Their argument appears to be, this just is an injury because they say it might sometimes--sometime in the future happen, and that it's archetypal, conclusory, and speculative standing injury that can't suffice to give this Court jurisdiction. In any event, there would be a lengthy chain of procedures that would apply, as we stated in our briefing, that would apply before any injury would actually occur to any state hospital funding.

Finally, I heard Ms. Hilton refer to parens patriae standing. It's black letter law, Your Honor, as I'm sure you're aware, that the State of Texas does not stand in its parens patriae in its suit against the federal government.

I understood Ms. Hilton to identify a number of different issues here that I think--I think the State of Texas' view gives them standing, and it's entirely based on a misreading of the guidance. I heard her say that the reference to health, on page 3 of the guidance, purports to provide--I believe it says, "Hospitals and physicians have an affirmative obligation to provide all necessary stabilizing treatment options." I believe she quoted that paragraph on page 5,

rather, of the guidance. And she also quoted, on page 3, "Place health of a person in serious jeopardy or result in serious impairment or dysfunction of bodily functions."

Those are both reflections of what the statute requires, because, on the one hand, on page 3, emergency medical condition is defined as a medical condition that places someone's health in serious jeopardy. So that certainly doesn't expand the contours of what EMTALA requires. And furthermore, the statement on page 5, "affirmative obligation to provide all necessary stabilizing treatment options," that merely reflects what the stabilizing treatment definition in the statute says, which is that--I don't remember the exact wording, but it's such medical treatment of the condition as may be necessary. So--

THE COURT: Well, but you recognize, when talking about these definitions, that they do constrict the definition. It is not as broad as the definition included in the EMTALA statute itself. I mean, I think that was a fair--you might have an answer for it, but I think that's a fair observation that, on page 3 of the guidance, an EMC includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, can place the health of a person, including pregnant patients, in serious jeopardy.

EMTALA itself, of course, has an entire other

phrase that focuses on the unborn child that is excluded from this. And so it is narrowing the definition for purposes of this memo.

MR. HEALY: I disagree that it's narrowing. I would say that it's explaining--

THE COURT: It completely excludes multiple words from the definition. I mean, it's like the--well, the warning of a selective quotation that we all got in law school. You don't cut out critical portions of a case quotation. How is this any different?

MR. HEALY: The consequences of this argument would be astounding, Your Honor. The consequence of this would be essentially that every agency guidance document that doesn't merely parrot the exact phrase of the statute would be final agency action and would suffice to give a state standing to sue, and that just cannot be.

THE COURT: Before we get to the ramifications, again, let me get an answer to my question before we go on. Do you agree that the statute--I'm sorry--that the memo's definition of EMC excludes a portion of the definition from the statute itself?

MR. HEALY: Where are you referring, Your Honor?

THE COURT: Page 3, which I just read, of the memo, in defining an EMC, it excludes--talks about the--could place the health of a person, including pregnant patients, in serious

jeopardy or result in--et cetera, et cetera.

The definition of EMC in EMTALA, in the statute itself, talks about immediate medical attention could reasonably expect to result in placing the health of the individual, open parenthetical, or, with respect to a pregnant woman, the health of the woman or her unborn child, close parenthetical. That is excluded from the memo. That's all I'm trying to recognize. This is a point they have made that, look, the statute talks about both the patient, including the pregnant patient, and an unborn child. And an unborn child is just not mentioned here.

MR. HEALY: So what this says, Your Honor, is that an EMC includes medical conditions of sufficient severity that, in absence of immediate medical attention, could place the health of this person, including pregnant patients, in serious jeopardy. I think that this is an example of a portion of the definition of emergency medical condition that this comprises. So it's not an incorrect statement or an inaccurate reflection of what the statute says. It merely provides an example of something that could be an emergency medical condition.

And that's our position with respect to this case entirely. What this document says and what this document does is provides an example of one type of stabilizing treatment that may, for certain emergency medical conditions, be required as determined by the hospital and, therefore, should be offered

and can be rejected under the terms of the statute. That reflects exactly what the statute does. It just provides an example of that care.

THE COURT: If a doctor encounters an indigent patient with complications of pregnancy loss, which is listed as an example of an EMC on page 4 of the memo, and does not provide either Methotrexate therapy, D&C, removal of one of the fallopian tubes, hypertensive therapy, et cetera, is that a violation of EMTALA?

MR. HEALY: I'm not sure I follow the question. Can you repeat?

THE COURT: If a doctor encounters an indigent patient--

MR. HEALY: Yes.

THE COURT: I've included "indigent" so it can be brought within the terms of EMTALA.

MR. HEALY: Uh-huh.

THE COURT: Make sense?

MR. HEALY: I think EMTALA applies with respect to hospitals that are Medicare-recipient hospitals, regardless of whether or not the person is indigent.

THE COURT: Okay. Nevermind. Go ahead. What's your next argument?

MR. HEALY: In any event, I was speaking about Ms. Hilton's points. She appears to read the guidance to

require the provision of nonemergency care. But the whole context of the guidance is EMTALA and the provision of emergency care within emergency rooms at covered hospitals.

THE COURT: This is an interpretation of EMTALA. It's bringing light to what, in your view, is required all along. Is this binding on HHS staff?

MR. HEALY: Is it binding on HHS staff?

THE COURT: Uh-huh.

MR. HEALY: It is a document that informs the public of what the law means. So I don't--I'm not sure that I know how to answer the question.

THE COURT: Well, I feel-- So it's 3:07. I can't remember when we started. I feel like, mostly, we've been just playing word games, and I'm really not trying to do that with you, honestly.

MR. HEALY: No, I fully understand.

THE COURT: Honestly. It's difficult. I've stood at podiums many times where judges are asking very specific questions. If you don't understand, I'd be glad to explain it further. I'm really not trying to play word games. I'm trying to give you a chance and really give you a window into what's concerning me, which is, I hope--I think most litigants view that as an opportunity; wow, I basically get to go back in chambers and get a view--

MR. HEALY: Just so you're aware, Your Honor, I'm

not trying to be difficult here. I'm just-- Your question to me was, is this document binding on HHS staff, and I don't know how to answer the question, because the purpose of the document--

THE COURT: So you're not sure. It might be; it might not be. You just don't know.

MR. HEALY: No, I'm not saying that I'm not sure. I'm saying that it doesn't fit with the purposes of the document. The document is meant to inform the public. What does it mean for the document to be binding on HHS? It's a document issued by HHS, and--

THE COURT: Is that Mr. Ely, not Healy?

MR. HEALY: I'm sorry?

THE COURT: Is that Mr. Ely, not Healy?

MR. HEALY: That's Mr. Beckenhauer.

THE COURT: Beckenhauer. I'm sorry, Mr. Ely.

MR. HEALY: Mr. Ely is at the back.

So I think if you're pushing me to answer a yes-or-no question, I think the answer would have to be no, because the purpose of the document is to inform the public, and it's not meant to identify what agency staff are supposed to be doing. It's certainly distinguishable from the *Texas vs. EEOC* case, which I may understand, Your Honor, to be--pardon me, I need some water--referring--because there, the whole point of the Fifth Circuit's ruling in the *Texas vs. EEOC* case

was that the particular agency guidance there had provided a rubric, a specific set analytical framework that the agency needed to follow in order to demonstrate whether or not there was a Title VII violation by an employer.

And here, there isn't any of that. Here, this is--the purpose of this document is to inform the public. So I think if--to be clear, I think the answer to your question is no.

If I may, Your Honor, I'd like to turn to the AAPLOG and CMDA's associational standing.

THE COURT: Okay.

MR. HEALY: It's unrebutted in the reply briefing that was filed last night that there were any indicia of traditional membership. They didn't come back with any identification of financing of the organizations or how the organizations are structured. I mean, there may be indicia of traditional membership, but there's nothing in the record about that.

Moreover, they haven't demonstrated that any of the members have standing. The answer I heard on that point from Mr. Bangert was a citation to the Donna Harrison declaration, but she was somebody who was testifying in her official capacity as an officer of AAPLOG, and she isn't one of the member declarants from AAPLOG. The member declarants from AAPLOG, as Your Honor mentioned in the previous discussion of

this, they merely suggest that they are worried about the potential consequences for this, based, I imagine, on the State and Plaintiffs' misreading of the guidance. And that certainly doesn't suffice for standing purposes.

Their claim that the guidance requires emergency departments to provide elective abortions is just wrong. Emergency departments provide emergency care. They do not provide emergency elective abortions any more than they provide nose jobs. They are there to provide emergency care for individuals who have emergency medical conditions. And that's exactly what the guidance says, and that's what's going on here.

Moreover, CMDA, which I understand to be the only plaintiff who has brought the RFRA claim, has the separate problem that they haven't demonstrated any specific facts showing the types of information that you would need to resolve a RFRA claim. And therefore, under the third prong of the *Hunt* inquiry for associational standing, we just don't know enough, and those individuals would have to stand in for CMDA, and therefore, CMDA doesn't have standing for this additional reason.

With respect to final agency action, Your Honor, as I mentioned before, this is not the consummation of an agency decision, let alone the type of decision--the type of document that would bind the public in any way. As I mentioned, this is

a far different case than the *Texas vs. EEOC* case, which actually spelled out an analytical framework for the agency that bound the agency itself. It's not even like *Luminant*, which is another case we've cited from the Fifth Circuit, where there were notices of violations from the EPA. That was not final agency action.

Here, we don't even have that. Nobody is being told by this document, Your Honor, that there is any likely violation under any particular circumstances. Instead, the document reflects that the determination of whether there's an emergency medical condition and the proper stabilizing treatment for that emergency medical condition is a decision that's up to the reasonable discretion of the hospital or the provider. And the hospital or provider, therefore, must offer that treatment to the patient, including if that is pregnancy termination, and then the woman can deny it, if she wishes not to have the procedure.

THE COURT: Where in the statute does it specify that an emergency medical condition includes ectopic pregnancy, complications of pregnancy loss, emergent hypertensive disorder, such as preeclampsia with severe features?

MR. HEALY: So I think that the declarations describe in great detail why those conditions--

THE COURT: Where in the statute?

MR. HEALY: What the statute says, as I'm sure Your

Honor is aware, is that an emergency medical condition is a medical condition manifesting itself by acute symptoms--and the acute symptoms are spelled out in a great amount of detail in the declarations--and it's something that could be expected to result in placing the health of the individual or, with respect to the pregnant woman, the health of the woman or her unborn child--and I'm happy to discuss that in a bit--serious impairment to bodily functions, serious dysfunction of any bodily organ or part. And each of those conditions, for the reasons described in the declarations, falls within those definitions.

THE COURT: Okay. Is it settled law, in your view, to go back to final agency action, that EMTALA preempts any countervailing state law that prohibits or restricts an abortion in medical emergencies?

MR. HEALY: EMTALA says that any statute that directly conflicts with--that any state statute or local statute that directly conflicts with the terms of EMTALA is preempted.

THE COURT: I'll try one more time. Is it settled law, in your view, that EMTALA preempts any countervailing state law that prohibits or restricts abortions in medical emergencies?

MR. HEALY: It would depend on the particular circumstances, Your Honor, because if-- I can't answer that

question with respect to abortions at large, because it would only cover an abortion to the extent--as the guidance says, to the extent that there was an emergency medical condition for which that abortion would be the proper stabilizing treatment.

THE COURT: Where in the statute does it define stabilizing treatment to include Methotrexate therapy, dilation and curettage, removal of one or both fallopian tubes, and hyper--anti-hyperintensive therapy?

MR. HEALY: So it says 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 patient from a facility, which includes a discharge.

And so, to the extent that those treatments that you just answered, Your Honor, fit within that definition, as per the reasonable judgment of the hospital, then they would be required by EMTALA.

THE COURT: So are you saying that they are not included specifically in the statute, but they're built into the definition?

MR. HEALY: I am saying that they are certainly not mentioned in the statute, but they are--they're only built into the definition to the extent there actually is an emergency medical condition for which that is the stabilizing care.

THE COURT: Okay.

MR. HEALY: With respect to final agency action, Plaintiffs plead these ultra vires claims--for which I understand their intent may be to try to get around the final agency action requirement under the APA. We put some argument in our briefing with respect to why that is not proper. Ultra vires claims are highly disfavored, and they are, in fact, referred to by then Judge Kavanaugh on the D.C. Circuit as a Hail Mary pass. And when there is a mere dispute of interpretation, that's not an appropriate time to raise ultra vires claims. They haven't responded to that at all, so far as I could see in their reply, and I didn't hear any response from counsel here--

THE COURT: Well, the argument that I hear--call it ultra vires; call it, you know, whatever you want--is that the memo goes beyond the statute, that the statute--you know, like, it's just common administrative procedure litigation, just common. Does the statute permit an agency to do this allegedly new thing that happened. I think that's what they're arguing. And so--

MR. HEALY: Well, I understand that's what they're arguing, but I think the scope of ultra vires claims is extremely narrow. You have to--

THE COURT: Okay. Assume with me that I'm not going to allow them to enforce or seek a true ultra vires claim, in whatever view you think that means. How is the

memo-- Just respond to the merits, as opposed to a pleading argument. How does the memo not go beyond the statute--

MR. HEALY: Well, the--

THE COURT: --given the detail that's provided, given--

MR. HEALY: I mean, their arguments are several-fold as to why it does go beyond the statute in their view. I think it's all premised on a misreading of what the guidance document actually does, for the reasons that I have said over and over at this point.

But I think this case boils down to pretty much a very simple dispute between us and Texas. Texas would read us to be reading abortion into the statute, and we would be reading them to be excluding it from the scope of a potentially reasonably necessary medical care to stabilize an emergency medical condition. So the question is, which one of those is correct?

And we have ample authority, Your Honor, for the notion that EMTALA does not conceive of exceptions to medical care for the very reasons that are discussed in the declarations. They are highly--the line-drawing is highly difficult, you know, to determine where life ends and health begins. And there isn't a separate rule for abortions. This is an instance of the canon of construction illustrated in *Bostock*, Your Honor, where, when Congress sets forth a

generally applicable rule and doesn't conceive of exceptions in that generally applicable rule, courts apply the broad rule.

Any contrary interpretation would imply, like I mentioned before, that emergency medical care would not be available to pregnant patients for whom an abortion termination--a pregnancy termination would be appropriate stabilizing care. And there's no evidence in the statute--statutory text that that was something that was intended by the text.

THE COURT: Let me ask you a hypothetical on that front. I'm going to keep trying.

MR. HEALY: Sure.

THE COURT: Assume that a mother presents to a hospital and does not have an--a pregnant mother. Does not have an emergency medical condition, but the baby has an emergency medical condition. What is the doctor's obligation under EMTALA in that circumstance?

MR. HEALY: So that depends--the answer to that question is defined in the statute. So an emergency medical condition is a medical condition manifesting acute symptoms, blah, blah, blah, that places the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

So when a pregnant patient shows up--and let's say the baby is in distress but the mother is not. That would be

an emergency medical condition, and then the doctor would determine what the appropriate care would be within his reasonable medical judgment. And--

THE COURT: The doctor would have an obligation to stabilize the unborn child?

MR. HEALY: The doctor would have an obligation to offer the stabilizing care--

THE COURT: Assuming that the patient consents and doesn't refuse the treatment that's offered, of course, under the statute.

MR. HEALY: It's the purpose of EMTALA. The whole point of EMTALA is to make sure that doctors were not refusing patients their reasonably medically necessary care.

THE COURT: So you have an obligation to offer to stabilize the baby, and the mom says, yes, please do that; that's why I'm here. Stabilize child?

MR. HEALY: Yes.

THE COURT: Okay. Assume that a mother has a non-- a pregnant mother has a non-pregnancy-related EMC, just, like, a severely broken arm. But the baby is fine, baby has no emergency medical condition. What's the doctor's obligation there?

MR. HEALY: Again, if emergency medical condition exists--and it sounds like, in your hypothetical, it would-- then the doctor would have to provide appropriate stabilizing

care.

THE COURT: All right. Baby is fine. Pregnant mother shows up. Baby is fine. The mother has a pregnancy-related EMC where she will lose a major bodily function if stabilizing treatment is not provided. The only way to stabilize is to separate the child from the mother and the baby will die. It's pre-viability. What is the doctor's obligation?

MR. HEALY: So the--

THE COURT: So now we have--

MR. HEALY: The statute says that the obligation is to determine whether or not an emergency medical condition exists. It sounds like one would in this situation. And then the hospital and provider would determine what the reasonable medical care would be under that circumstance and would offer it to the patient, and then the patient would decline it or not.

THE COURT: Where in the statute does it specify that the doctor should provide stabilizing care for the mother in that circumstance, which would result in the death of the unborn child, as opposed to stabilizing the unborn child and not the mother? Where is that language--

MR. HEALY: So I think it's important--

THE COURT: Hold on. I just want to make--

MR. HEALY: This is--

THE COURT: I just want make sure you understand my question. We've got to go one at a time. She's going to be--she's already so mad at me, and you're making it worse.

MR. HEALY: Apologies.

THE COURT: Where in the statute does it guide a doctor in that circumstance?

MR. HEALY: So I think--

THE COURT: And I'm looking for language of the statute in EMTALA.

MR. HEALY: Absolutely. Prepared to answer the question as best I can.

The statute differentiates between an unborn child and the individual in numerous instances. For example, in the definition of emergency medical care--emergency medical condition, obviously there's health of the individual or, when the individual is a pregnant woman, the woman or her unborn child. So they have set forth that term separately.

Furthermore, in Section (d)(2)(A)--or, pardon, Section (c)(1)(A)(ii) refers to increased risks to the individual and, in the case of labor, to the unborn child. In part (c)(2)(A), there is a reference to minimizing risk to the individual's health and, in the case of a woman in labor, the health of the unborn child.

Numerous instances throughout the statute, they are setting forth the definition of unborn child separate from

the--references to unborn child separate from references to the individual. And that indicates, in the text of the statute, that the term "individual" was meant to be different than the term "unborn child."

And if you turn to--

THE COURT: In the case of a pregnant woman, the individual means the pregnant woman and her unborn child.

MR. HEALY: No. I think that's exactly the reading that we disagree with. The question is, does an individual have an emergency medical condition. In Section (b)(1), the individual has an emergency medical condition. So they either have it or they don't have it. And do they have it? We turn to the definition of emergency medical condition. That says, the term "emergency medical condition" means a medical condition, blah, blah, blah, blah, blah, placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child. Right? So the question of whether or not there is an emergency medical condition can be determined by whether the woman has an emergent issue or whether the baby is in distress.

If there is an emergency medical condition, the switch of the statute is flipped to On. You know, there is an emergency medical condition; then the stabilization requirement clicks in, and the doctor has to determine such medical treatment of the condition as may be necessary, and that's up

to the doctor's discretion to determine what the medical treatment that may be necessary. And, of course--

THE COURT: In your view, there's no language in the statute guiding this decision between the obligation to the pregnant mother and the obligation to the unborn child? Because there's dual obligations under the statute. There's language, but the doctor will decide?

MR. HEALY: Of course. In many instances, doctors will, of course, try to make sure that the unborn child and the woman are both okay. Right?

THE COURT: Okay. So--I understand. It leaves it-- Okay. I gotcha. It leaves it to the doctor--

MR. HEALY: And to be clear, that's exactly what the guidance says. The guidance says, you leave this to the doctor to determine if there is an emergency medical condition. So this isn't something that is outside the statutory bounds.

And to think otherwise-- And, you know, if there is, let's say, a conflict between the health of the woman and the health of the mother, the statute is clear what the outcome is then there, too, because it makes sure that the pregnant woman is offered the proper treatment, and then she can decline. It's up to the patient, up to the individual in part (b) of the statute, (b)(2), to determine whether to accept or decline that treatment.

And, of course, any contrary position which I

understand the plaintiffs to hold would result in--would be a reductio ad absurdum problem, because it would imply that Congress wanted to sub silentio exclude only abortions from the scope of emergency medical conditions and allow hospitals to stand by as women die.

THE COURT: No, I think--I don't understand that to be their position. I think their position is, if a state makes a reasoned--or even if it's unreasonable, in your view--decision about what is proper medical care and what's not proper medical care, under the state's authority to regulate just health and safety of their citizenry, your view is that EMTALA is broad enough to always allow the doctor to trump that decision of the state, I think. That there are obligations under federal law. If the state makes a decision that won't allow that, you trump; see the supremacy clause.

MR. HEALY: Let me--

THE COURT: And let me give you a hypothetical.

MR. HEALY: The-- Okay. Go ahead.

THE COURT: Let's say that the state-- We're in the future; we can harvest organs, or let's say that, you know, we are in dire straits, and some states begin to allow the harvesting of organs, like an extra kidney from poor people. Okay? And that's--some states are doing that, and let's say some states say, look, it will save poor Joe or poor Jane, but that's a step too far; like, as a society, we're not going to

go down that path.

And a patient comes to hospital. The only stabilization is an organ--liver, kidney, whatever it is--that's right there, and then that's the only stabilization that they can provide. If a state says, "Nope, we're not allowing that in our state," and it's the stabilizing treatment, under that circumstance, I think your view is, regardless of the state law, EMTALA requires the doctor to provide that stabilizing treatment.

MR. HEALY: Well, I think there's an issue there, because it sounds like, in your hypothetical, the organ would be an organ you're taking from somebody who doesn't have an emergency medical condition and you're giving it to somebody who does have an emergency medical condition? Am I understanding the hypothetical correctly?

THE COURT: The organ is in the back room.

MR. HEALY: Okay.

THE COURT: It's in a cooler, ready to go. It came from a person who was willing to give a portion of their liver or one of their kidneys for money. And some states say, we're not going to allow that; that--we have Ph.D. bioethicists and they say, we don't want to cross that path. It might save people, but I don't want to live in that world, and so we're not going to allow it. Other states allow it. But, somehow, there's an organ right there, but it did come from one of these

people, for whatever--just whatever, this hypothetical. What is a doctor to do in that case? Does EMTALA require that stabilizing care?

MR. HEALY: I think it's important to understand that the requirements under the statute are just whatever care is reasonably medically necessary, and it's what's within the capabilities of the hospital. So I don't think that--

THE COURT: Yeah. It's right there. They have a transplant team; we're ready to go.

MR. HEALY: Yeah, I don't know the answer to that question, Your Honor.

THE COURT: Well, why would it not--doesn't your answer have to be yes? Why would it not trump? I mean, to be consistent with your position-- I know it's an outrageous hypothetical. That's the point of the hypothetical.

MR. HEALY: Mine was as well.

THE COURT: I mean, how could it be anything other than, yeah, under our view of the law, federal law trumps, and if we live in a world where that kind of thing is permitted and that's the only stabilizing treatment available, then yes, a doctor must provide that transplant, even if it violates state law?

MR. HEALY: But I don't think that that's right, Your Honor, because the whole point of EMTALA is--

THE COURT: Well, then, what's the limiting

principle--what's the limiting principle for your position that doctors can trump state law?

MR. HEALY: Yeah, so--

THE COURT: I'm being very up-front with you. I'm trying to be helpful. I'm just trying to get answers.

MR. HEALY: It's a hard hypothetical, Your Honor, and I'm trying my best here. I think that the question would be, is it such medical treatment of the condition as may be necessary, and if it's objectively medically reasonable and--it should be offered. Right? So the answer is, I think, probably yes, if it's objectively medically reasonable.

THE COURT: Okay. All right. Let's say that a state passes a law-- Okay. We know that that's what the federal government is going to say, so let's pass a law instead that--and we'll just--I mean, let's just talk about abortion. That's what we're talking about. Let's say a state passes a law that says, all right, we've been following this litigation in Texas and Idaho; let's get out in front of this. Hey, instead of going straight at abortion, let's pass a law that bans any hospital, doctor, organization, et cetera, from ordering, causing to be brought into the state, buying the materials that are used in performing surgical or medical abortions. So the equipment, the medicines, you can't bring it in. Right? So, fine, you have this obligation, but we're going to take the tools away from you. Does EMTALA preempt

that statute?

MR. HEALY: It would depend if there's a direct conflict. And I think--again, I think no situation like this is alleged. But the question would be, is there a direct conflict with the requirements of EMTALA? And--

THE COURT: There are pregnant patients showing up with emergency medical conditions that require abortions, even under their view. And the hospital is saying, I can't bring the materials in to do it. All I've got to do is push, you know, "Order" on my app, but there's a state law that says I can't do it.

MR. HEALY: I think the question would be, is there obstacle preemption. I think that most courts I have seen who have interpreted the question of what direct conflict means typically include obstacle preemption within that definition. And so the question would be, does it amount--is it severe enough that it would amount to an obstacle to the requirements of the statute. I think that would be the question--

THE COURT: And that's what I'm asking.

MR. HEALY: --for the Court to consider.

THE COURT: Yeah. And that's what I'm asking you.

MR. HEALY: I think if it amounted to an obstacle such that the doctor wasn't able to provide such medical treatment as may be necessary, then the answer would be yes.

THE COURT: Okay. As I'm sure you're aware,

there's a federal criminal statute that criminalizes anyone from causing the mails to be used to deliver abortion-related materials, medicines, devices, et cetera. As a result of what you just said, is the argument that EMTALA is somehow, like, superseding or preempting a federal criminal statute? Because this statute is on the books.

MR. HEALY: It's a very hard hypothetical, Your Honor, because how two federal statutes interact with one another is a very, very difficult thing to determine. But in--

THE COURT: Yeah, we're in--there is a lot of open questions. I agree.

MR. HEALY: Right. And so, you know, what we did in our briefing and I think the way a court would analyze that question would be to look at, does EMTALA typically permit exceptions? Was that what Congress intended to do?

And so here, we have ample case law, the New York case, the California case--there's a case called *Morin* from the District of Maine that I don't think we cited in our briefing, but I'm happy to provide you the citation if you like--where the discussion ended up with, no, we don't think that EMTALA allows for these types of exceptions.

So whether or not the two-- Of course, a court would always attempt to read the two statutes in harmony, where possible, but--

THE COURT: If it amounted to obstacle preemption--

just like the state law, even federal criminal law, in your view, if it's obstacle preemption, a doctor or a hospital can bring those things into the state to be able to provide the stabilizing treatment--

MR. HEALY: No, it's a different question, Your Honor, because obstacle--

THE COURT: I'm intending it to be the same question. State law, just like the federal law, which we know exists--the state law, it's obstacle prevention--obstacle preemption; it's preempted by EMTALA. You can absolutely bring that in, and if the state--somebody in the state sues you or tries to, you know, charge you with something, say, cite the supremacy clause. Same answer for the criminal statute--

MR. HEALY: Well, no, because if it's two federal statutes, then the supremacy clause isn't operating.

THE COURT: Okay. So how does it--then what would happen?

MR. HEALY: What would happen is, you would attempt to read the two statutes together. You would look at the text of both statutes, see if they could be read together; try to apply them to see if they could be read together; and if there was a conflict, you might have to look to legislative purposes, you might have to look to other case law, you might have to determine which one gives. Where two federal statutes conflict with one another, there's a whole line of cases that determines

how to determine the outcome of that.

THE COURT: And which--

MR. HEALY: It's a highly complex inquiry.

THE COURT: And which one gives here? I mean, let's just say that the Court determines that the plain language of the statute--they conflict with one another. You know, that hospital is not going to be able to have the materials necessary for an abortion, and HHS just told me in this memo that the guidance requires it under certain circumstances. I have to be prepared for this or I'm in violation of EMTALA. I'm on the hook. But I have this other law. The only way I can do it is to violate it. I've got to bring it in?

MR. HEALY: I think that we would probably have a good argument as to why EMTALA would still require the provision of the care. I don't know if that would be the outcome. I honestly would have to think about it more.

THE COURT: Okay.

MR. HEALY: There's a clear statement rule for abortion exceptions, Your Honor, including in the ACA, as we cited in our briefing. ACA contemplates that EMTALA requires abortions. In discussing the state's ability to exclude abortion coverage from certain health plans, Congress made clear that EMTALA would cover abortion care in appropriate circumstances. And, in fact, the bill that created EMTALA

itself, in a separate provision of that bill, separately excluded abortion care. So where Congress wishes to exclude abortion care, it does so expressly. And I'm not sure that I saw a coherent argument to the contrary.

We've discussed the unborn child issue and our reading of those provisions. I'm happy to answer any other questions you have about that. In addition, the major questions doctrine, I think, doesn't require any different treatment of this statute with respect to its reading. I think the statutory text is clear. I think that the major questions doctrine, when you compare this to other cases in which the major questions doctrine has applied--for example, *West Virginia*, the most recent case, *vs. EPA*, or *NFIB*--those were cases dealing with vast impacts on American industry and millions of people.

And here, we have a single guidance document that informs the public of what the agency understands the law to require and to have always required. And it applies only with respect to that narrow subset of patients that show up at an emergency room and have an emergency medical condition for which an abortion would be the reasonably necessary care.

So it's certainly not a major questions doctrine case. Merely because abortion is an emotional issue does not make it a major questions case, and so I don't think that the major questions doctrine should apply here, and I think you

should apply normal statutory interpretation.

THE COURT: Okay. And on that normal statutory interpretation, I have to decide whether a direct conflict exists. Do you agree that 1395dd sub (f) is a conflict preemption provision? It's about conflict preemption. Correct?

MR. HEALY: Yeah, it says direct conflict. It's a conflict preemption provision.

THE COURT: And the language of the--I mean, some cases have described this type of formulation of a preemption provision as an anti-preemption provision. Basically states, do whatever you want, have a ball, unless it directly conflicts.

I mean, do you agree that this is--I mean, maybe you--I'm scared to even ask you because you might quibble with the words, but people have phrased these as anti-preemption provisions. Is that fair?

MR. HEALY: I'm not familiar with that term, but that may be how--

THE COURT: Yeah. I mean, it is saying, states, do everything you want to do, unless you directly conflict with us; then you can't.

MR. HEALY: Right. And that's--

THE COURT: Fair? I mean, do you read it the same way?

MR. HEALY: I think that's a fair reading of the statute, yes.

THE COURT: Okay. All right. What is a direct conflict?

MR. HEALY: I think a direct conflict is, like we've talked about before, either obstacle preemption or impossibility preemption.

THE COURT: Okay. So if the statute just doesn't address something specifically and a state does, that would not be a direct conflict?

MR. HEALY: No. I think you would look at was it--does the state law pose an obstacle to what the federal law is doing. I don't agree with that.

THE COURT: Okay.

MR. HEALY: Or is it an impossibility.

They have a number of arguments with respect to the various conscience provisions, Your Honor. As we stated in our briefing, the conscience provisions make clear that they were not intending to override emergency provision of abortions. And we have two cases that have directly held so much, and they haven't provided arguments that I can understand to the contrary about why we should understand the Weldon Amendment, the Coates/Snow Amendment to necessarily override EMTALA in all instances.

I think I would understand it to mean that you can

and should apply both, where you can apply both, and that's what has been reflected in the numerous guidance documents that were cited in both parties' motions. In this morning's--last night's--for me, this morning--reply brief, Plaintiffs contend that this is merely a political thing. This is a political football that is lobbed back and forth between democratic and republican administrations.

But the citations they provided to a document from the Bush administration, a document from the Trump administration do not state what Texas' position is, which is, abortion is never allowed, or that these conscience provisions in all instances override EMTALA's provisions. That's not a plausible reading of what's going on here.

THE COURT: And, in your view, it's--abortion is absolutely required, at times, under EMTALA?

MR. HEALY: At times, where it's determined to be the reasonably medically necessary care for a particular emergency medical condition, then yes.

THE COURT: And how does that square with Section 1395?

MR. HEALY: You're talking about 1395cc, control over practice of medicine?

THE COURT: Uh-huh.

MR. HEALY: So there are numerous instances of conditions of Medicare spending that similarly require a

particular baseline level of care. For example, we've cited in the regulations, there's a--you need to provide necessary dietary needs; you need to provide--I can't recall what the other example was now that we provided. But regardless, there are numerous instances throughout the Medicare statute and in the regulations where there is understanding that you can require the provision of some baseline care, which is all EMTALA does, without contravening 1395cc.

I would also note, Your Honor, that I don't think that Plaintiffs cite any case law, in their opening motion or their reply, in support of their position. I may be wrong about that, but I don't think I saw any.

With respect to notice and comment, Your Honor, I think this is similar to our final agency action argument. This doesn't create a binding norm. It just says abortions are not excluded from the provision of emergency medical care.

THE COURT: That's all it says, that they're not excluded? It says they're required under certain conditions.

MR. HEALY: Right. But the plaintiffs' position is essentially that this should be considered excluded. It certainly doesn't say that. Right? It certainly doesn't say that abortions are excluded from the scope of care. It provides a broad rule of what types of care. It's reasonably medically necessary care should be provided. That's a broad rule. If there were an intention to exclude abortion care, you

would think that there would be some textual or historical indicia of that, and we haven't seen any of that from Plaintiffs. We've seen the opposite, in fact.

THE COURT: Well, the statute doesn't address abortion. It addresses treatment of unborn children. This, post-*Dobbs*, understandably from your side, says, wait, wait, wait, wait, wait, don't forget about this statute. Let's talk about it. We're going to talk about abortion. We're going to define EMCs in the realm of pregnant patients. We're going to define stabilizing treatment in the realm of pregnant patients who are facing emergency medical conditions. We're going to talk about preemption of state law, potential fines, potential exclusion from Medicare. Despite that, doesn't go too far to require notice and comment. I mean, we have, you know, two medical associations saying, we have good-faith religious beliefs that--we're very concerned about the language here, and it would require us, subject to significant fines or exclusion from programs on which we just rely-- That is not enough to require notice and comment, according to the United States. And I understand that position.

What else would be required? When is the threshold passed? If that doesn't do it, what would have done it?

MR. HEALY: So I think the question is, does this create a binding norm. Look at what the statute does. Does this do something more than that. Right? Is this a change in

the status quo, for example. There was a guidance document issued in September 2021, which the plaintiffs do not challenge, that recognizes--several guidance documents issued the same month that recognize that these types of treatments are appropriate care for emergency medical condition.

THE COURT: Abortion was not mentioned in those documents.

MR. HEALY: That's true. But the treatments, which--like, for example, dilation and curettage--

THE COURT: Dilation and curettage could be a lot more than abortion. I mean, that could be--

MR. HEALY: But often it is abortion. It's probably one of the most often that that provision is used--that treatment is used.

THE COURT: So the question is, what takes it over the--what takes it over the line?

MR. HEALY: What takes it over the line?

THE COURT: What would take it over the line that would require notice and comment? If not this, what else, in the United States' view?

MR. HEALY: So I think you would have to examine, does this actually create something that is new. Does this change the status quo and create some binding norm that people didn't understand to be the case beforehand and didn't understand to be part of the statutory framework. The mere

fact that this is not something that-- The reality here is that this is not an issue that had come up before. Right? Because *Dobbs* just happened. Right?

THE COURT: And *Dobbs* created a fairly new world order. I mean, I think we can agree on that. But this is not new?

MR. HEALY: But I think that--I think that--

THE COURT: Help me square that.

MR. HEALY: So--

THE COURT: Everyone is trying to figure out, what do we do.

MR. HEALY: Right. I completely understand that.

THE COURT: Good-faith reasonable disagreements between parties, between people, 50 years of precedent gone. Trying to figure out what do we-- How is that not new? You just said if this--I would have to decide if this is new. How, under those circumstances, where you're defining a world post-*Dobbs*, how is that not new?

MR. HEALY: So if--

THE COURT: Because your argument is, this is how it's been all along. But you just also recognized that *Dobbs*-- *Dobbs* changed everything.

MR. HEALY: Well, just because there's a change in the underlying legal framework doesn't mean that what the guidance document says is new. Here, we have--

THE COURT: It's talking about preempting state laws that are contrary--that state laws did not exist or were not enforced. They were laying in wait before *Dobbs*.

MR. HEALY: That was--and that was always the case--

THE COURT: It is talking about something that, post-*Dobbs*, did not exist.

MR. HEALY: And that was always the case. There was just no need to express it, because everyone was providing these treatments. Now the legal landscape has changed, and the government has a strong interest in reminding hospitals what their obligations are under EMTALA. As the declarations we've put together state repeatedly, doctors understand that these--this kind of care is sometimes, in unfortunate circumstances, required. And the mere fact that it wasn't necessary to state it because everyone was providing that treatment previously does not mean that, now that they have stated this preexisting thing that everybody understood, it now requires notice and comment.

It's similar to the example that I--a little bit loopy hypothetical I gave about Massachusetts. I mean, if Massachusetts passes a law that says you can't treat gunshot wounds in ERs, would a notice from the agency saying, hey, remember, everybody, you have to treat gunshot wounds--would that require notice and comment? The answer has to be no.

With respect to the arbitrary and capricious standard, it's highly deferential, as I'm sure Your Honor is aware. It just needs to be reasonable and reasonably explained. As we've just discussed, it's not a change in position. There aren't reliance interests here, because it isn't a change in position. Texas hasn't identified even a single doctor or hospital that contends that it is not what they believed the statute to require. There are good reasons for issuing it. Confusion after *Dobbs* is an important issue for the government, to inform people of their preexisting obligations, and that easily meets the arbitrary and capricious standard.

I would like to just very quickly pause and look to see if there are any other issues I wanted to dispute with respect to these arguments before I turn to the constitutional claims, if you would allow me. I apologize.

On the arbitrary and capricious claim, Your Honor, the plaintiffs appear to argue that there is--that this is arbitrary and capricious because there's no risk of being denied care. I think that's flatly wrong, Your Honor. I think that the whole point of issuing this guidance document was to ensure the provision of care that has continued to be provided after the legal landscape has shifted.

With respect to the spending clause, Your Honor, they appear to have, I think, two arguments--let me take a

quick sip of water--appear to have two arguments, one with respect to--one, maybe we can call it their surprise argument, that this was a retroactive condition that was unconstitutional.

As I've mentioned, again, their claim to be surprised is based on a misreading of this document. It doesn't require elective abortions. Emergency rooms never require elective abortions.

THE COURT: Let me ask you, them--let me ask you exactly what I asked them. And in my notice, I asked you to be prepared for it as well. Is that the focus, that--whether someone claimed to be surprised or not claimed to be surprised, or is this a question of law, or is it a mixed question?

MR. HEALY: I think it's a mixed question. I think it's a question of law as applied to fact. You can't answer the question without fact. And here, I think there really aren't any sufficient facts in the record to demonstrate that there is surprise. I think in the--

THE COURT: Well, you have folks saying that they weren't surprised. They have folks saying, no, no, no, I never have and I never will.

So I think there probably is-- I have sworn testimony from both on both sides of this.

MR. HEALY: I disagree with that characterization of what's in the record for Plaintiffs. I think that they have

not provided anybody that says that this understanding--the accurate understanding of the guidance was not what they previously understood EMTALA to require. And, in fact, I think that Mr. Bangert conceded that abortions are sometimes reasonably medically necessary to treat emergency medical conditions. And that's what the guidance says. And so I don't think that there's any plausible argument that they could be surprised based on the facts here.

And it's a legal determination, but it applies to what the facts are. Right? And here, we have numerous doctors saying that this is what they have always understood. We have court cases that demonstrate that there are no exceptions to EMTALA's requirements. We have guidance documents; court cases go back until the nineties; guidance documents going back until 2011. We have numerous other aspects of the record here that demonstrate that there isn't a *Pennhurst* problem. This isn't a situation where the state wasn't on notice that there was a condition and the general bounds of what that condition is.

Here, the condition is, okay, to accept this Medicare funding, you need to make sure that you comply with the provision of accurate medical care--adequate medical care, rather. So I think that their surprise retroactive condition claim fails for those reasons.

THE COURT: Where is the notice in the four corners of the statute? I mean, if it's a legal determination, how

does the statute itself put people on notice that the full spectrum of abortion procedures that are specified in the guidance memo are required? I understood Mr. Bangert saying that there are limited exceptions where, even within their sincerely-held religious beliefs under the Catholic doctrine, that they are permissible and they will and they have provided those. But that is a limited exception.

This is broader. I think that's part of what the fight is about. You don't dispute that. Right? I mean, this is broader than what Mr. Bangert's clients are willing to provide?

MR. HEALY: Now I'm confused about that, Your Honor. I thought I would have said yes, but have also said that that isn't actually adequately pled in the record. But now I'm confused, because I heard him concede that his clients would actually provide that care. So now I think the answer might be no.

THE COURT: Okay. Well, I'll give him a few minutes, given that he has been brought up, to clarify this. But just assume with me that his clients believe that this is broader. They would provide some and they have provided some, under these limited circumstances, that comply with their religious beliefs and their ethical obligations, but otherwise, no.

Where in the statute did it give notice that, well,

no, sorry, if you're going to accept our funds, even under those conditions that you think are out of bounds, you must do it? And, if not in the statute, has HHS ever issued a guidance document specific to abortion like this one?

MR. HEALY: Well, it hasn't issued a guidance document specific like this one, as I said before, because there wasn't a need for it. Everybody understood that this is what was required. And there are court cases going back to the nineties that demonstrates that there are no exceptions to EMTALA's broadly applicable rule.

And I think my answer to your question is, how were they put on notice? Well, they were put on notice by accepting conditions that are--that do not, on their face, contain exceptions but are very specific. Right? These conditions are extremely specific. They are highly technical. And--

THE COURT: Which conditions are you talking about?

MR. HEALY: I'm talking about the definition of emergency medical condition and what hospitals have to do to stabilize that condition and the--you know, the fact that they need to provide such medical treatment of the condition as may be necessary. And we have case law--

THE COURT: You think that's talking about a specific condition? I read these as broad and generic.

MR. HEALY: I think that that is applying to--as courts have recognized going back years, that requires the

objective provision of reasonably medically necessary care. Right? Whatever that care is. If there were--if there were an exception here, it would be written into the statute. The text of the statute does not allow for exceptions, and it should be--it's an application of the *Bostock*--

THE COURT: Okay. So the definition of EMC itself is what put them on notice?

MR. HEALY: Yes, and the fact that they voluntarily agreed to be placed on notice to accept Medicare fundings on acceptance of EMTALA--of--rather, of Medicare funding. And so of course they were put on notice of what they were agreeing to, because what they were agreeing to is actually highly specific. And, of course, if there was any lack of clarity, over many years, they could have sought clarification, as the Court noted in *Bennett*.

They have a second argument, this coercion argument, that the amount of money being conditioned is, you know, just so vast that this is gun-to-the-head, a la *NFIB*. That was--all of the cases that we were talking back and forth about with respect to coercion are just much vaster sums of money than what is actually being bargained here.

The bargain here is the condition of the State of Texas to receive Medicare funding for two Texas hospitals. That's it. And they don't say what that number is, but they do say that the combined total--the declaration from their general

counsel of Texas Tech says that the combined total of Medicare and Medicaid funding that they receive is $148 million, which is a drop in the bucket for Texas budget and certainly not the type of gun-to-the-head *NFIB* scenario where all of the state's Medicaid funding was being conditioned upon the receipt of this Medicare expansion. It's apples and oranges. And their attempt to say, hey, well, look at the enforcement mechanisms--if we fail to comply, we're subject to these penalties--that's not the proper inquiry, Your Honor. The proper inquiry is, you look to see what bargain is being placed in front of the state at the time they are accepting.

And states could always--the State of Texas could determine that its hospitals--these two hospitals don't want to continue with Medicare. The agency informs me that that's a process that typically is a 15- to 30-day notice process, but if the Texas--if Texas wanted to, they could do it on the drop of a dime. They could do it immediately. There isn't, you know, some large ramp-down period that would be prejudicial to Texas. So that's always an option here. And particularly with the small amount of money, there just isn't a coercion claim.

THE COURT: You have five minutes.

MR. HEALY: All right. I'd like to finally discuss the RFRA claim, unless you have any questions with respect to the Tenth Amendment or nondelegation claims.

THE COURT: No, go ahead.

MR. HEALY: Okay. There is a great amount of information that Mr. Bangert discussed that is not in the pleadings and not in evidence, and Defendants respectfully object to the discussion of that. I was not prepared to discuss any of this information with respect to Mifepristone and the-- All that information is not anything that appears in their briefing.

They have not demonstrated a substantial burden for the same reasons that they haven't shown that there's associational standing for CMDA. There's no identification of a particular individual's religious beliefs, and there's an extremely compelling interest, Your Honor, in protecting maternal health and in protecting the public welfare.

And as to the question of whether it's narrowly tailored with respect to a particular individual's religious beliefs, that's a question that will depend on that particular individual's religious beliefs, and none of that is apparent in the record. So the RFRA claim fails. And their free exercise claim fails for the additional reason that this is obviously a generally applicable standard that is rationally related to a legitimate government interest.

With respect to the balance of the equities, Your Honor, and the scope of the injunction, I was surprised to hear Ms. Hilton say that she's seeking a nationwide injunction, because on page 1 of their motion, they appear to be seeking an

as-applied injunction. So that took me by surprise.

We would say that any harm here, if any, is weak. There wouldn't be any remedy to a concrete injury. This is an injury that has not been demonstrated by identifying any particular medical condition that falls within the gap between the Texas statute and the guidance as properly understood. And any enforcement action would be brought under the statute, not the guidance.

THE COURT: And the sovereign interest of a state in, like, my bodily organ example just has to give? Whatever that interest is, it is not as strong and must give to EMTALA's generalized stabilization requirement?

MR. HEALY: The sovereign interest--

THE COURT: States can make those value judgments if they want, but they cannot override EMTALA's stabilization requirement?

MR. HEALY: Sovereign interest has to be demonstrated, Your Honor. Here, it isn't.

THE COURT: They have been fairly clear in their state laws. Texas has kind of gone out of its way to make very clear that abortions are not permissible in the state except for certain conditions.

MR. HEALY: The question is, what type of care would fall within the gap. Is there any type of care that would fall within the gap between Texas law and EMTALA? I am

not sure. And they haven't provided any example, despite repeated invitations to do so. You asked them the question. We've asked them the question in our briefing. And they haven't responded.

Our interest is strong here. As I mentioned, we have a strong interest in informing the public of what the agency understands the statute to mean.

They have requested an as-applied injunction, so our position is that if the Court disagrees with all of the arguments that we have made today, it should issue an injunction that only applies with respect to the two Texas hospitals and with respect to any members of AAPLOG and CMDA that have actually demonstrated an irreparable harm.

THE COURT: Okay. So assuming I find that it's unlawful for some reason, the injunction would apply to the two Texas hospitals and the medical associations' members? Is that--

MR. HEALY: Yes, Your Honor.

THE COURT: Okay. I just want to make sure I heard you correctly. Okay.

MR. HEALY: And I think that's not inconsistent with what the State appears to--the plaintiffs appear to seek in their papers, but apparently it's different today.

The Court shouldn't issue a broader injunction. To the extent you can read Plaintiffs' pleading, which appears as

applied and narrow as applied to the guidance and enforcement of the guidance, it would require the invalidation of the guidance itself. And the Court can't enjoin the government from expressing a position on what the law means. It could enjoin a particular agency action, but it can't enjoin--you know, it can enjoin the challenged guidance document, which is the agency action that is identified here, but it can't enjoin the world at large, or enjoin the government from thinking certain thoughts.

So does Your Honor have any further questions on this or any other issues?

THE COURT: No, I won't enjoin you from thinking certain thoughts. I promise not to do that.

Okay. Mr.-- I'm sorry. Pardon me.

MR. BECKENHAUER: Your Honor, with the Court's indulgence, before Plaintiffs rebut, might I have a moment to consult with my colleague for just a brief moment?

THE COURT: Sure.

MR. BECKENHAUER: Thank you.

(COUNSEL CONFERRING)

MR. HEALY: Thank you, Your Honor, for the brief indulgence.

At the start--at the very beginning of my argument, we got a little bit hung up on definitions. I wanted to clarify just for the record a couple of things. "Abortion" is

a term that appears throughout the U.S. Code. The guidance doesn't purport to define it for any purposes of EMTALA or any other federal statute. We think the guidance is naturally read to use "abortion" to mean induced termination of pregnancy, as I was attempting to discuss at the beginning. That, in fact, is the same definition that Mr. Bangert mentioned during his presentation at 45 CFR 283.2. We don't take the position that HHS is using the definition differently than the CDC has, and we don't quibble with that definition. Regardless, it seems to be common ground that whether resolving an ectopic pregnancy would be called an abortion or not, it is an emergency medical condition requiring stabilizing care.

Second, in case it wasn't clear, this is the first time that they have mentioned nationwide relief. It doesn't appear in their pleadings and it doesn't appear in their briefing. In fact, the brief says otherwise at page 1, like I mentioned.

Finally, the guidance was issued in the wake of *Dobbs* due to potential confusion, but its focus is not reproductive rights. It focuses on emergency care that EMTALA requires, including for pregnant patients. That has never changed. That has continued to be the case. And that's why the guidance document does not reflect the understanding that Texas imagines it does.

Thank you, Your Honor.

THE COURT: Thank you, Mr. Healy.

Ms. Hilton, you have ten minutes. And, Mr. Bangert, since you came up so often, I'll give you five minutes, if you want to prepare.

MS. HILTON: Your Honor, Mr. Healy mentioned a number of--his answers to a lot of your hypotheticals were that EMTALA would leave decisions to the doctor about treatment. And what that really means is that EMTALA leaves it to the state, because physicians are not all-knowing, they are not all-powerful. They don't create law. And so when it leaves it to a physician, it leaves it to the physician to comply with state law and to provide appropriate treatment. This would be the same-- You know, just as, when a physician is providing care to a patient, cannot prescribe illegal drugs, that would be a state law. That's the same situation here.

To clarify, one of the points Mr. Healy made was that he said Plaintiffs never said abortion is--that Plaintiffs said abortion is excepted from stabilizing treatment. That is not Plaintiffs' position. Plaintiffs' position is that abortion and whatever the appropriate stabilizing treatment is is governed by state law.

Mr. Healy argued that there is no injury to the state and that the state has failed to plead an injury for failure to conduct notice and comment. But we pled the claim, and we have alleged facts showing the injury, and that is

enough. The United States Supreme Court, in *FEC vs. Cruz*, which we cited on page 13 of our reply brief, says, contrary to what Mr. Healy said: The Court does assume that, for standing purposes, the Court accepts as valid the merits of the plaintiffs' legal claims. So that's on page 13 of our reply brief.

Mr. Healy said that the guidance document is not binding and it is not final agency action because it doesn't bind the public. I come back to, Your Honor, what we've already discussed earlier this afternoon. That's belied by the fact by not only the additional requirements that the mandate has by its terms, which we've discussed, but also belied by the fact that the federal government has cited it in its lawsuit seeking to enforce its terms in Idaho. So it is most certainly being treated by the government as binding.

As to the point Defendants raised about ultra vires claims, for these purposes, it doesn't really matter. I think the parties agree, and the federal government agrees in their briefing, that whether those claims are brought as ultra vires claims for violations of the Constitution or not, they are cognizable under the APA for exceeding statutory authority.

There was some discussion with Mr. Healy about the fact that emergency rooms, he contends, do not authorize elective abortions any more than they authorize nose jobs. But the guidance requires that the physician provide all

stabilizing treatment options, which includes abortion, according to the guidance, and the patient gets to choose. And so if she gets to choose in a situation in which her life is not at risk, then that is an elective abortion under Texas law and its framework.

Mr. Healy and Defendants have cited in their briefing the ACA provision that says that there's nothing in the ACA that purports to supersede any requirement of EMTALA. And the defendants are using that to support their position that EMTALA requires abortions. That's simply not the case. That provision does not dictate--or doesn't say anything about abortion. It doesn't say what EMTALA requires at all.

And that's similar to--Defendants have pointed out some regulations requiring certain psychological services. I believe that's what Mr. Healy was searching for when he was talking about nutrition, and then you--psychological services, I believe, from your briefing. But those two statutes are--they're similar to this emergency requirement to provide stabilizing treatment in that the government does not say, you have to provide sufficient nutrition, and that means three vegetables a day, and that means X, Y, Z. It just says "sufficient." And so that leaves it to the doctor. And when that leaves it to the doctor, it leaves it--that's really to the state. The same thing for psychological services. It doesn't say, you will see this therapist three times a week.

It says, you, you know, provide some services. So it's the--that's totally consistent, and that actually, in our view, supports--it supports Texas' claims; it doesn't support Defendants' position.

As to preemption, direct conflict, obstacle preemption, EMTALA specifies that the preemption provision only applies when it--on a direct conflict. It's not obstacle preemption. And so an example, I think, that I would offer to the Court of what that preemption provision really means would be, if Texas were to pass a law that says no one can provide medical treatment to anybody unless they can pay, that would be the direct preemption. That would be a problem under EMTALA.

THE COURT: On your point about--your prior--immediately prior point that leaving it to the doctors means leaving it to the state law to regulate, tell me why.

MS. HILTON: Because the federal government doesn't regulate the practice of medicine. If it's not state law, then--I mean, then I don't know who it would be, but it's not the federal government.

And certainly physicians, at least in Texas, are bound by the Occupations Code. There's the Texas Medical Board. There are certain requirements and--of being a licensed physician in Texas, and EMTALA doesn't purport and explicitly says that it does not intrude into that sphere.

THE COURT: Okay. And Mr. Healy also argued that

this is just all hypothetical; Texas has not provided any examples of where, yes, there's daylight. I think we agree that there's daylight between the Texas exceptions and the EMC definition, but it's all just academic. What's your response to that?

MS. HILTON: Your Honor, I would go back to--I think that the most obvious example would be what we talked about earlier, about a mental health situation, where the health of the mother is in jeopardy but her life is not. Under the guidance, it leaves open the possibility that an abortion would be an appropriate stabilizing treatment in that situation, but that would not be allowed under Texas law.

Your Honor, with respect to the nationwide injunction, Defendants are correct. They have corrected me. That is in our briefing. I still believe that an option for the Court is to issue a nationwide injunction for the reasons that I mentioned earlier, but I think most prominently the fact that the APA requires a rule to be set aside for failure to comply with procedural requirements and that it would be appropriate that that rule--the setting aside would apply nationwide, and not in a piecemeal format. But certainly Texas would request that at least an injunction would run as to the State of Texas, and obviously to our named co-plaintiffs.

With respect to Mr. Healy's point that we've provided one declaration from Mr. Bentley at Texas Tech, we've

also provided Victoria Grady's declaration, who works at Texas HHSC. And, in Texas, you have to have a Medicare provider agreement in order to be a part of Texas Medicaid, and that's talking billions of dollars at risk then. If CMS provider agreements are terminated, then we're talking about the loss of Medicare and Medicaid funds, which is tens of billions of dollars to the state.

And with that, unless the Court has any questions, I'm going to yield the floor to my colleague, Mr. Bangert.

THE COURT: All right. Thank you, Ms. Hilton.

MS. HILTON: Thank you.

THE COURT: Mr. Bangert?

MR. BANGERT: I will attempt to be exceptionally efficient.

I believe the reason you called me up here was because there was discussion of this purported concession that I made that my--members of my Plaintiffs somehow would agree to do abortions in a broad variety of contexts. I think Your Honor has it exactly right. I'm simply restating what my own declarants have said in their declarations. I would direct you to the declaration of Donna Harrison, in which she points out specifically: When continuation of a pregnancy is an immediate threat to the life of the mother, AAPLOG's view is that physicians may separate the mother and the unborn child, regardless of gestational age. That's their view.

However, they object because the mandate is--quote, in paragraph 21, the requirements of the mandate are broader than life of the mother situations and include elective abortions where the woman's life is not at stake. And that is what we object to. And it's very clear. We go into detail in our declaration about that.

By the way, our individual member doctors who also sent a declaration specifically ascribe to the doctrines and beliefs that are stated in detail in AAPLOG's declaration, as well as in CMDA's declaration by Mr. Barrows. So it all kind of fits together. The bottom line is, if the mandate requires my clients' members to provide elective abortions, it violates their religious beliefs, full stop, and that's very clear from the declarations.

THE COURT: And in their view, they have just argued to me, this doesn't require any elective abortions. So help me understand again why, in your client's view, this would require an elective abortion. And this kind of goes back to a similar question I asked Ms. Hilton. Where in-- There is a gap. There is sunshine between Texas' exceptions and the United States' definition, but where are the actual examples, to the extent they are necessary? Ms. Hilton told me about mental health. What about you?

MR. BANGERT: Right. I mean, the best example we have--I mean, mental health is clearly one. The other example

would be the incomplete medical abortion, the Mifepristone abortion in which the woman presents; the life of the mother could be saved, along with the child--

THE COURT: With the provision of the Preg--help me--Preg--

MR. BANGERT: You could produce Progesterone.

THE COURT: Progesterone. Thank you.

MR. BANGERT: Yes. It's also called abortion reversal. It's an issue right now that's being debated post-*Dobbs* quite heavily. There's a lot of science being done on this. In fact, they cited some cases. We also have cases where experts are fighting this out in court right now.

But the bottom line is, there is--this is not in the record, but if you look at the case law, there's a big debate going on. Progesterone actually is an effective treatment therapy, but they're saying we can't do it. We can't do it. And that's what we would do. And so the other option is to let the woman either die or abort, when there's an available treatment there to save the life of the baby and the mother.

And I think that puts a lie to--that puts a lie to their argument that, well, no, it doesn't require elective-- That's an elective abortion, because you're taking treatment off the table and then you're saying, tell the woman, you will abort.

Now, you could actually let the pregnancy progress. You could let it progress without treatment. In about a quarter of those cases, the baby might survive, but about 75 percent, they're going to die. If they die, that creates an emergency medical condition where you're going to have to treat.

And so the problem with it is, it creates a situation where our physicians are required to offer abortion when the life of the mother and the life of the baby could both be saved at the same time. That's what we object to. That's an elective abortion, because elective abortion, as we see it, are abortions where the life of the mother is not immediately necessarily at risk. And there's an option to treat both, and yet, that's taken off the table by this guidance document. Taken off the table.

THE COURT: Okay.

MR. BANGERT: We object to that, and our physicians very clearly state in their declarations they will not do that.

The other thing-- I wanted to point out a couple more things. We more than adequately stated our beliefs in our declarations. I did get the objection that I raised things that weren't in the pleadings. Most of my argument came directly from the text of the mandate itself. I think the objection was I might have mentioned the word Mifepristone. But, Your Honor, they said it first. If you look at their

declarations, the declaration of Dr. Peaceman, page 19: In the situation evaluation, it should be performed regardless of whether a woman took medication such as Mifepristone with or without Misoprostol. So he's talking about the Mifepristone/Misoprostol regime.

Same comes up just a little bit later in the declaration of their fourth doctor. Dr. Nordlund talks about, in paragraph 11, the Mifepristone/Misoprostol regime.

So this has already been discussed in the declarations, the fact that Mifepristone and Misoprostol are available medications to induce abortion or to induce--or to induce the evacuation of the uterus.

And by the way, medication abortion, as stated in the guidance document, that is--almost without exception, that means Mifepristone. And so this has always been part of the case.

One other thing, Your Honor, that I want to raise, and that is, there was a colloquy early on in the argument in which my friend on the other side talked about does it really mean anything in the guidance document that we excluded the unborn child from the definition of emergency medical condition? Does that really have any effect?

There's a second change, and I neglected to mention it. It was in my outline, but I got distracted. There's a second subtle change to the language in the guidance document

that varies from the EMTALA statute. The EMTALA statute talks in terms of individuals, parenthesis, pregnant woman or unborn child. The guidance document talks about persons. It says, you must treat a person, bracket, including a pregnant woman. Right?

Now, that may seem like a very innocuous change, a very innocuous shift. Individual, person; what's the difference? Well, I would offer, Your Honor, that actually has some significance legally. And why is that? Because there's a very hot debate taking place right now about whether or not unborn children are persons for purposes of the 14th Amendment, for purposes of federal law. If they are, they are entitled to due process, which means you can never sanction abortion. Right? That would give--that would empower Congress, under the 14th Amendment, to prohibit abortion nationwide if unborn children are persons under the 14th Amendment.

But Roe vs. Wade was very clear. It said, federal courts have never recognized unborn children as persons under the 14th Amendment. And so by making that switch, individual to person, you're plugging into that long line of federal case law that expressly won't recognize unborn children as persons.

THE COURT: Okay.

MR. BANGERT: I don't think that was accidental.

THE COURT: Okay. I understand. Thank you, Mr. Bangert.

All right--

MR. HEALY: Respectfully, Your Honor, if we might--Go ahead. Yeah. If-- That covered a lot of ground. If it would be possible to have Ms. Talmor make two very, very brief points, we would be very gracious.

THE COURT: So it's argument, response, rebuttal.

MR. HEALY: If that's not appropriate, we are happy to not, but--

THE COURT: Yeah. It's 4:22. So, yeah, I think they have rebutted your argument. I have your briefing. Let's move on.

I'll take it under advisement today. I understand the law--Texas law is going into effect August 25th; is that right?

MS. HILTON: Yes, Your Honor.

THE COURT: And I take it from your briefing, you're hoping for an answer before then?

MS. HILTON: Yes, Your Honor.

THE COURT: Okay. I will do my level best to get that done. I understand your allegations. I understand the United States disagrees with them.

I have a civil trial on Monday. That's great timing. But we will be working as fast as we can. I know that both sides want an answer to this, and I'll get it to you as fast as possible, and we will get you an answer one way or

another before the 25th.

I want to thank both sides for-- I know it's been a long afternoon. I know you've come a long way to provide that argument. So thank you, both sides, for your professionalism. The Court takes it under advisement.

This hearing is adjourned.

(END OF HEARING)

I, Mechelle Daniel, Federal Official Court Reporter in and for the United States District Court for the Northern District of Texas, do hereby certify pursuant to Section 753, Title 28, United States Code, that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

/s/ Mechelle Daniel **DATE** AUGUST 20, 2022

MECHELLE DANIEL, CSR #3549
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