NO. 23-727

IN THE

Supreme Court of the United States

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

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

REPLY BRIEF FOR THE PETITIONER

JOHN J. BURSCH
ERIN M. HAWLEY
MATTHEW S. BOWMAN
LINCOLN DAVIS WILSON
JACOB P. WARNER
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001

RAÚL R. LABRADOR
ATTORNEY GENERAL
JOSHUA N. TURNER
Counsel of Record
ALAN M. HURST
JAMES E.M. CRAIG
700 W Jefferson St #210
Boise, ID 83720
josh.turner@ag.idaho.gov
(208) 332-3548

JAMES A. CAMPBELL
JULIE MARIE BLAKE
RORY GRAY
ALLIANCE DEFENDING FREEDOM
44180 Riverside Pkwy
Lansdowne, VA 20176

CHARLES J. COOPER
DAVID H. THOMPSON
PETER A. PATTERSON
MEGAN M. WOLD
COOPER & KIRK PLLC
1523 New Hampshire NW
Washington, DC 20036

Counsel for Petitioner

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Regulations

INTRODUCTION

According to the administration, a hospital that accepts Medicare dollars must violate state laws that govern the medical profession, and the state where the hospital is located can do nothing about it. For that to be the case, EMTALA would have to be extraordinarily clear about its preemptive effect. But the exact opposite is true.

EMTALA is an amendment to the Medicare Act, which is itself built on a longstanding foundation of state regulation of the practice of medicine. That is why the Act declares, "Nothing in this subchapter"—including EMTALA—"shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. 1395. EMTALA does not displace state law with a national standard of care, nor does it require specific procedures for particular medical conditions. EMTALA takes a state's regulation of medical practice as it finds it. It could not operate otherwise.

That point is evident from its text. EMTALA's stabilizing-treatment requirement is limited to "the staff and facilities *available* at the hospital." 42 U.S.C. 1395dd(b)(1)(A) (emphasis added). This means a hospital "must provide stabilizing treatment within its capability and capacity." CMS, *State Operations Manual*, App. V, at 48, https://perma.cc/L499-GU4C (*State Operations Manual*). A medical facility's capabilities are defined not only by its physical space and staff's skillset but also by the "specialized services that the hospital provides." *Ibid.* And its medical staff's capabilities are defined by the "scope of their professional licenses," *ibid.*, which states alone set.

The services a hospital and its staff can provide are necessarily dictated by state law—just like a federal public defender must abide by the ethical rules of the state where he is licensed to practice. CMS recognizes this, and Medicare's regulations demand it. Hospitals that participate in Medicare "must assure that personnel … meet … applicable standards *that are required by State or local laws*." 42 C.F.R. 482.11(c) (emphasis added). For example, in Idaho, a doctor can lose his license for the inappropriately prescribing narcotic drugs, Idaho Code § 54-1814(11), (12), or for performing an unlawful abortion. Idaho Code § 54-1814(6). EMTALA does not countermand these directives; that is why the circuits have uniformly construed EMTALA as an anti-dumping statute that does not require particular treatments or impose a federal standard of care. Idaho.Br. 26–27. And it is why the administration points to *no* prior enforcement example where a hospital was cited for failing to provide a medical treatment in violation of state law. Indeed, the United States has never interpreted EMTALA that way until now.

In short, the administration's attempt to construct an abortion mandate out of a statute that does not even mention it is an impossible task. It would require this Court to dismiss EMTALA's repeated protection of "the unborn child" and the multiple federalism canons that apply here. And it would allow the federal government to pay hospitals to violate state law, exempting emergency-room doctors from the state-law standards of practice that govern the treatments they are authorized to provide. Nothing about that nullification of state law is narrow, and it is not, and will not be, limited to abortion.

The district court's judgment should be reversed.

REPLY ARGUMENT

I. The administration's strained EMTALA reading sinks under federalism canons.

The administration gives short shrift to three federalism canons, saying almost nothing about the presumption against preemption. But the administration's new EMTALA interpretation contravenes each of them.

First, the presumption against preemption safeguards "the historic primacy of state regulation of matters of health and safety." *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 485 (1996). Perhaps Congress *could* set uniform national health standards. U.S.Br.47 (citing *Gonzales* v. *Oregon*, 546 U.S. 243, 271 (2006), a case where the Government did not). But the question is whether Congress *has*. And in applying the presumption to a federal statute "susceptible of more than one plausible reading, courts ordinarily accept the reading that disfavors pre-emption." *Altria Group, Inc.* v. *Good*, 555 U.S. 70, 77 (2008) (cleaned up). All the more so given EMTALA's savings clause, which shows "Congress took care to preserve state law," not wipe it out. *Wyeth* v. *Levine*, 555 U.S. 555, 567 (2009).

Second, Congress must "speak with a clear voice," imposing conditions "unambiguously" in a Spending Clause context. *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17–18 (1981). The administration does not contest this, insisting instead that "Congress is not commanding Idaho to do anything; the funding recipients are hospitals, not the State." U.S.Br.46. The bizarre implication is the federal government can preempt state law by entering into private contracts with private hospitals, and states are powerless to stop it. U.S.Br.46–47. No authority supports this

startling, anti-federalist preemption principle; the Government cannot bind a state through third-party contracts. And it is not possible to say EMTALA "unambiguously" created an abortion mandate when no federal court or official so construed it until now.

Finally, EMTALA does not constitute "clear congressional authorization" settling the important political issue of whether states retain control over the practice of medicine in emergency rooms—including in the abortion context. Idaho.Br.22 (quoting *West Virginia* v. *E.P.A.*, 597 U.S. 697, 723 (2022)). The administration's only response is to reject the major-questions doctrine's application outside an agency's assertion of delegated authority. U.S.Br.48–49. But HHS is exercising its authority to enforce EMTALA both by suing Idaho and by issuing the memoranda it relies on to justify its position. And the administration's objection puts form over substance. The judiciary has developed a variety of "clear-statement rules" that "help courts 'act as faithful agents of the Constitution.'" *West Virginia*, 597 U.S. at 736 (Gorsuch, J., concurring) (quoting A. Barrett, *Substantive Canons and Faithful Agency*, 90 B.U. L. Rev. 109, 169 (2010)). Similarly, the major-questions doctrine protects the "separation of powers." *Id.* at 737.

So the issue is not whether the doctrine applies outside the delegation context but whether the administration has announced "a fundamental revision of" EMTALA, "changing it from one sort of scheme of regulation into an entirely different kind." *Id.* at 728 (cleaned up). The answer is yes: just considering abortion, the administration would displace 22 states' laws, impact thousands of hospitals, and jeopardize billions of Medicare dollars. Leg.Br.39–42. No clear statement in EMTALA authorizes that result.

II. EMTALA does not mandate medical treatments that violate state law.

EMTALA imposes no federal standard of care, much less a standard that conflicts with state abortion law. The administration's novel position has no support in EMTALA's text, purpose, or history.

A. EMTALA requires only those medical treatments that are "available" at a hospital.

1. The practice of medicine has long been the province of state and local regulation. In Idaho, for example, a doctor can be disciplined and lose his license for "[p]roviding health care which fails to meet the standard of health care provided by other qualified physicians or physician assistants in the same community or similar communities." Idaho Code § 54-1814(7). The same is true if he inappropriately prescribes controlled substances, Idaho Code § 54-1814(11), (12), engages in assisted suicide, Idaho Code § 39-4514, or performs an unlawful abortion. Idaho Code § 54-1814(6). And in determining malpractice liability, Idaho law forbids the use of federal laws and regulations "for establishing an applicable community standard of care." Idaho Code § 6-1014.

Congress constructed the Medicare Act to preserve this state-law foundation by prohibiting federal officers from exercising control over state and local medical practices. 42 U.S.C. 1395. The administration tries to limit this unqualified savings clause, saying "EMTALA's stabilization requirement was enacted by Congress itself, not imposed by a 'Federal officer or employee.'" U.S.Br.29. But the provision says, "*Nothing in this subchapter* shall be construed to

authorize any Federal officer ….” 42 U.S.C. 1395 (emphasis added). This language makes clear that the provision prohibits EMTALA from allowing a federal officer to *enforce* the statute in a way that dictates the practice of medicine—that is precisely what the administration attempts to do here.

EMTALA’s text reinforces that state law sets the standard of care. When a patient has an emergency medical condition, the facility must provide “such treatment as may be required to stabilize the medical condition” or transfer the patient. 42 U.S.C. 1395dd(b)(1)(A), (B). EMTALA doesn’t define “treatment,” but its provisions establish that the term is limited to treatments available under state law.

EMTALA requires that treatment need only be provided “within the staff and facilities *available* at the hospital.” 42 U.S.C. 1395dd(b)(1)(A) (emphasis added). Sensibly, CMS interprets this to mean that a hospital need not provide a treatment that falls outside the scope of its staff’s professional licenses. *State Operations Manual* at 48. And CMS has reiterated that required treatments are limited not only by physical or staffing constraints but by the “specialized services that the hospital provides.” *Ibid.*

The understanding also flows from Medicare’s implementing regulations. Hospitals that participate in Medicare “must assure that personnel are licensed or meet other applicable standards *that are required by State or local laws*.” 42 C.F.R. 482.11(c) (emphasis added). So Idaho hospitals that accept Medicare dollars must ensure their doctors provide care in conformance with community medical standards. And they must also ensure their doctors do not provide treatments that are illegal under state law.

CMS has held this view for more than 20 years. CMS, *Program Memorandum re Hospital Capacity-EMTALA* (Nov. 29, 2001), https://perma.cc/7Y94-HKUD (same understanding of "capabilities"). Only five years ago, CMS was asked if EMTALA surveyors "investigate state law and state scope of practice regulations while conducting an EMTALA investigation." CMS, *Memorandum re FAQs on EMTALA* 3 (July 2, 2019), https://perma.cc/LM3Y-VJ6D. CMS said yes: if staff "perform services that are outside their scope of practice, the hospital may be out of compliance with § 489.24(a)(1)." *Ibid.* That makes no sense if EMTALA authorizes an Idaho doctor to perform unlawful procedures outside his "state scope of practice," such as psychosurgery, Idaho.Br.30, or an abortion for a minor without parental consent.

The American Hospital Association—one of the United States' amici—has also acknowledged that "[s]tate law … may limit a hospital's capability" under EMTALA.[1] Without explanation, the AHA now abandons its prior understanding and argues that EMTALA requires specific care even when state law forbids it, AHA.Br.16–27. It was right the first time. As the AHA asserted in 2018, if hospitals "cannot admit involuntary psychiatric patients without violating state law," there is no "direct conflict" with EMTALA because "the hospital lacks capability or capacity to stabilize the patient."[2] In response to the AHA's position, CMS reaffirmed the importance of "State scope of practice" limits and said that if a

---

[1] Letter from Ashley Thompson to Kate Goodrich, M.D. at 9 (Oct. 5, 2018), https://www.aha.org/system/files/2018-10/181009-cl-emtala.pdf.

[2] *Id.* at 9–10.

"hospital doesn't have the ability to … provide stabilizing treatment" for an emergency medical condition, EMTALA required it only "to arrange an appropriate transfer."[3] Legal ability under state law was plainly part of CMS's understanding of a hospital's treatment capabilities. That is as true today as it was in 2018.

2. To head off the flexibility of EMTALA's stabilization requirement, the administration asserts that a pre-viability abortion is the only treatment for some pregnant women experiencing emergency medical conditions. U.S.Br.14–16. But the administration vastly overstates this point.

Treatments for ectopic and molar pregnancies are not abortions under Idaho law. *Planned Parenthood Great Nw.* v. *Idaho*, 522 P.3d 1132, 1203 (Idaho 2023); Idaho Code § 18-604(1)(c). And conditions like pre-eclampsia, eclampsia, and HELLP Syndrome are "life-threatening situation[s]" for which Idaho law allows "life-saving surgery" or "early delivery." J.A.547–48, 573–78; see J.A.567–68; accord J.A.514–15, 519–20, 522–23. The same is true for sepsis, J.A.546–48, see J.A.571–72; accord J.A.515–516, 518; and for severe heart failure—though in that instance, immediately terminating the pregnancy could be "the worst first thing to do for the sake of the health of the mother." J.A.566–76; see J.A.547–48; accord J.A. 513–14. Life-saving treatment or a C-section are also permitted for placental abruption. J.A.569–70, 572–73; see J.A.547–48; accord J.A.513–14. So too for a pregnant woman whose water breaks before her child is viable, U.S.Br.24–25, because Idaho's life-of-the-

[3] CMS, *FAQs on EMTALA* at 3.

mother exception would apply. Idaho Code § 18-622(2)(a). This is why the stay panel below had no trouble concluding that every circumstance described by the administration's declarations involved life-threatening circumstances under which Idaho law would allow an abortion. J.A.667.

The administration says if Idaho is correct, then the preliminary injunction has "no practical effect." U.S.Br.21. Not so. The administration demands that EMTALA's application turn not on objective clinical standards, U.S.Br.26 n.5; *id.* at 34 n.9, but on emergency-room doctors' subjective "medical judgment." *E.g.*, Resp. in Opp'n to Appls. for a Stay at 35, *Moyle* v. *United States*, Nos. 23A469 and 23A470 (U.S. Nov. 30, 2023). The consequence is that EMTALA would not be limited to the truly life-threatening scenarios the government highlights, or even to abortion. If the administration's position is accepted, doctors at Medicare-funded hospitals would become essentially unregulated, with their own medical judgment superseding all state laws regulating the practice of medicine. That is the exact opposite of 42 U.S.C. 1395's premise that doctors continue to be governed by state law. And no clear statement suggests that is what Congress intended.

3. The administration tries to show that its position is grounded in a historical interpretation of EMTALA. But EMTALA's understanding by HHS, courts, providers, and Congress only reinforce that state and local standards govern treatment. It provides no support for a purported abortion mandate.

HHS Guidance. The administration cobbles together a purported EMTALA enforcement history based on HHS rules and guidance predominantly

about other issues. U.S.Br.16–18 & n.2. Those materials are inapposite.

HHS's 2008 Rule was about conscience protections, not EMTALA, and it did *not* say that EMTALA requires abortions that violate state law. On the contrary, it thought an EMTALA exception to conscience protections unnecessary because no commenters indicated any hospitals objected in those circumstances. *Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008). The 2008 Rule cited nothing indicating that any court or agency has ever interpreted EMTALA to require abortions that violate state law.

The 2019 Rule was similar. Again, it was not issued by CMS but by HHS's civil rights office that enforces federal conscience protections. And "like the 2008 Rule," the 2019 rule declined to "go into detail as to how its provisions may or may not interact with other statutes or in all scenarios." *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170, 23,183 (May 21, 2019). More fundamentally, however, the administration's recognition that EMTALA's stabilization requirement accommodates an individual's conscience but not state law makes no sense. EMTALA's text is not more deferential to one than the other.

The administration's 2021 guidance likewise fails to advance its case. That document did not use the word "abortion"; it merely stated that a stabilizing treatment "could" include "dilation and curettage (D&C)." CMS, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experi-*

encing Pregnancy Loss 4 (Sept. 17, 2021, revised Oct. 3, 2022). In Idaho, a D&C would be an available treatment option if a pregnant woman miscarried. In California, a D&C could be available if a pregnant woman was experiencing a non-life threatening emergency. Nothing in the 2021 guidance suggests an abortion mandate, particularly not abortions that violate state law.

Notably, the response to the administration's new position proves that it broke new ground. Once HHS announced its abortion mandate in 2022, medical associations immediately sued and submitted comments in opposition to HHS. See *Texas* v. *Becerra*, 623 F. Supp. 3d 696 (N.D. Tex. 2022); Ethics & Pub. Pol'y Ctr., *EPPC Scholars and Others Respond to HHS's Proposed Rule on Conscience Rights in Health Care* (Mar. 7, 2023), https://perma.cc/KMT3-QMHN (collecting comments).

CMS Enforcement. For the first time in this litigation, the United States proffers spreadsheets of CMS hospital survey records as support for its supposedly longstanding enforcement policy. U.S.Br.16 n.2. Not even close. The records, which are the product of findings by state survey agencies, see 42 U.S.C. 1395aa(c), show that the administration's position is truly novel and lacks any historical basis.[4]

---

[4] An EMTALA complaint triggers a state survey agency investigation, followed by regional office review, medical expert review, and, if necessary, an Office of the Inspector General investigation. *E.g.*, CMS, *Memorandum re Clarification on Release of 60-Day Quality Improvement Organization Reports* (Mar. 27, 2024), https://perma.cc/B9T9-YGF8.

Of the 115,000 survey summaries, the administration identifies just seven that it says support its abortion mandate. U.S.Br.16 n.2. Five involved treating ectopic pregnancies (2010-2016 file, Rows 3732, 8645, and 25,877; 2017-2023 file, Rows 25,709 and 45,218), which Idaho law plainly allows. And one involved a failure to stabilize a pregnant woman's pain and said nothing about the facility failing to provide a necessary abortion. (2010-2016 file, Row 20,800.)

The final example involved a Catholic hospital that would not perform an abortion. The record concludes the hospital violated EMTALA *not* because of that refusal but because the hospital should have "transferred [the woman] via ambulance to a facility that would treat her." The reason? Transferring the patient via her friend's car—rather than an ambulance—"compromise[ed] the health of the *unborn baby* and patient." (2010-2016 File, Row 16,963 (emphasis added).) In other words, the hospital was faulted for allowing a transfer that failed to protect a pregnant woman *and* her unborn baby. That the *only* relevant enforcement example identified expressly identifies a hospital's obligation to both a pregnant mother and her unborn child shows how baseless the administration's newfound theory of EMTALA is.

Courts. No court has recognized that abortion is the required stabilizing treatment under EMTALA. Idaho.Br.28. This Court will look in vain for such a holding in the four cases the administration references, U.S.Br.18–19, as Idaho already explained. Idaho.Br.28. And every court of appeals recognizes that EMTALA requires no particular treatment, only treatment otherwise available at the hospital. Idaho.Br.26–27; Argument I.B., *infra*.

Providers. As for providers, see U.S.Br.19, "[m]edical practitioners across the nation provide effective, evidence-based emergency care to pregnant women on a daily basis without resorting to induced abortions." AAPLOG.Br.1. These practitioners understand that, while rare conditions may give rise to life-threatening emergencies that permit treatment in every state, "induced abortions are not necessary emergency medical care required by EMTALA." *Id.* at 5 (cleaned up). Many Medicare providers, both institutional and individual, adhere to the Ethical and Religious Directives for Catholic Healthcare and have never offered the abortions the administration now says EMTALA requires. USCCB.Br.16–17. The absolute silence of any enforcement history against such providers speaks volumes. And, as noted above, when the administration announced its new EMTALA interpretation, many medical practitioners objected and sued.

Congress. Unable to find support for an EMTALA abortion mandate within the statute, the administration looks to a later-enacted statute—the Affordable Care Act. 42 U.S.C. 18023. It points to subsections (a) and (b), which limit subsidies for abortion and allow insurers to restrict coverage for it, and then jumps to subsection (d), which states that nothing in the law "shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law," including EMTALA. 42 U.S.C. 18023(a)-(b), (d). The administration says that putting these provisions in the same section means that EMTALA requires abortions that violate state law. U.S.Br.19–20. But the administration skips over the intervening subsection (c), which contains an express savings clause for state law about abortion:

> **No preemption of State laws regarding abortion**
>
> Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

42 U.S.C. 18023(c)(1). Subsection (c) manifests Congress's express purpose—the "touchstone" of preemption, *Wyeth*, 555 U.S. at 565—and shows how subsection (d) fits within the overall EMTALA framework. If state law allows abortion as a stabilizing treatment (*e.g.*, in California), a hospital does not violate the ACA's abortion subsidy prohibitions by performing it.

The administration's reliance on a statute enacted 20 years after EMTALA that *respects* state abortion laws shows that the government cannot overcome the presumption against preemption here. See *United States* v. *Sw. Cable Co.*, 392 U.S. 157, 170 (1968) ("[T]he views of one Congress as to the construction of a statute adopted many years before by another Congress have very little, if any, significance.") (cleaned up).

Finally, explicitly prohibiting funding for abortion on the one hand, Idaho.Br.5, 34–35, while apparently requiring it on the other, does not jibe with the Spending Clause clear-terms rule. Contra U.S.Br.44–45. Idaho's laws regulating the practice of medicine are not preempted.

B. Numerous circuit decisions hold that EMTALA does not set a national standard of care.

EMTALA requires participating hospitals to provide the same stabilizing care to every patient within the services available at the hospital. Idaho.Br.24–32. Thus, while hospitals cannot refuse to provide a patient with stabilizing care they would provide to others, *In re Baby "K"*, 16 F.3d 590, 595–596 (4th Cir. 1994), EMTALA does not require services that hospitals cannot provide for anyone. Indeed, Congress prohibited HHS from "direct[ing] or prohibit[ing] any [particular] kind of treatment or diagnosis" in its administration of the Medicare program. *Goodman* v. *Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989) (per curiam).

The administration sets up and then knocks down a strawman, asserting that Idaho is advancing a "nondiscrimination rule," a tactic this Court "rejected" in *Roberts* v. *Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per curiam). U.S.Br.28. There, the lower court held that "to recover in a suit alleging a violation of [42 U.S.C.] 1395dd(b), a plaintiff must prove that the hospital acted with an *improper motive* in failing to stabilize her," and this Court disagreed. 525 U.S. at 250 (emphasis added).That is not remotely similar to Idaho's argument here, which is that EMTALA takes state standards of care as it finds them. If state law allows a doctor to provide a particular treatment, then that service is available at a hospital for EMTALA purposes. But if state law prohibits a particular treatment, then the facility cannot provide it to anyone, no matter the circumstances.

This result is consistent with EMTALA's anti-patient-dumping purpose. No one disputes that EMTALA protects individuals "with and without insurance." US.Br.30 (quoting *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991)). The parties dispute what treatment those individuals must receive. The administration says EMTALA requires emergency care that "medical experts" recommend in a given situation. U.S.Br. 30; *id.* at 34–35 n.9 (promoting "evidence-based standard of care"). That may be true, but only if the service is otherwise "available" at the medical center. *E.g. Moses* v. *Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 582 (6th Cir. 2009); *Thomas* v. *Christ Hosp. & Med. Ctr.*, 328 F.3d 890, 893–96 (7th Cir. 2003); *Burditt* v. *HHS*, 934 F.2d 1362, 1368–69 (5th Cir. 1991). Nothing suggests the hospitals in the administration's cases could *not* provide the care requested.

Here, the question is whether EMTALA requires hospitals to provide treatment *they cannot provide for anyone*. It does not. As every circuit has held, EMTALA imposes no "national standard of care." *Texas* v. *Becerra*, 89 F.4th 529, 543 (5th Cir. 2024), *petition for cert. filed*, No. 23-1076 (U.S. Apr. 3, 2024); Idaho.Br.26–27 (collecting cases). EMTALA merely "requires hospitals to provide … stabilizing treatment … in a nondiscriminatory manner." *Torretti* v. *Main Line Hosps., Inc.*, 580 F.3d 168, 173 (3d Cir. 2009); accord, *e.g.*, *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 144 (4th Cir. 1996) (EMTALA bars "disparate treatment").

The administration says the caselaw shows only that EMTALA liability is distinct from "actionable … negligence or malpractice." U.S.Br.31. But the cases also hold that EMTALA does not "establish guidelines

for patient care." *Harry* v. *Marchant*, 291 F.3d 767, 773 (11th Cir. 2002); accord, *e.g.*, *Bryan* v. *Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) ("the legal adequacy of [a hospital's] care is [ ] governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt"); *Becerra*, 89 F.4th at 543 ("the practice of medicine is to be governed by the states"); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) (EMTALA "does not set a national emergency health care standard"); *Baker* v. *Adventist Health, Inc.*, 260 F.3d 987, 993 (9th Cir. 2001) (EMTALA "is not intended to create a national standard of care"); *Phillips* v. *Hillcrest Med. Ctr.*, 244 F.3d 790, 798 (10th Cir. 2001) ("EMTALA does not set a federal standard of care").

Retreating, the administration concedes that EMTALA's screening rule may require "only uniform treatment among the indigent and insured," U.S.Br. 31 n.6, while insisting EMTALA's stabilization rule requires more because it "impose[s] an obligation … to achieve a specific objective." *Ibid.* Yet *both* provisions require covered providers to achieve specified objectives. Compare 42 U.S.C. 1395dd(a) ("to determine whether … an emergency medical condition exists"), with 1395dd(b)(1)(A) ("to stabilize the medical condition"). Just as state standards guide emergency-room compliance with EMTALA's screening rule, they also determine how covered providers may comply with its stabilization rule. Idaho.Br.25–32; contra U.S.Br.35–36. There is no basis—certainly not in the statutory text—to treat screening and stabilization differently. And in both instances, doctors must act using lawfully available treatments.

C. EMTALA requires hospitals to care for an unborn child.

Reading EMTALA's medical-treatment provision to require abortion specifically also contradicts EMTALA's repeated requirement to protect and care for an "unborn child." Idaho.Br.32 (citing 42 U.S.C. 1395dd(e)(1)(A)(i), (c)(2)(A), (e)(1)(B)(ii), and (c)(1)(A)(ii)). This is no accident; a prior version of EMTALA referred merely to the "individual" or the "patient." See Pub. L. No. 99-272, § 9121, 100 Stat. 82 (1986). Then amendments clarified that "EMTALA imposes obligations on physicians with respect to both the pregnant woman *and* her unborn child," *Becerra*, 89 F.4th at 544 (emphasis added), including a duty to deliver the unborn child of a woman in active labor. 42 U.S.C. 1395dd(e)(3)(A). As the Fifth Circuit reasonably concluded, "[t]he inclusion of [this] one stabilizing treatment indicates … others are not mandated." *Becerra*, 89 F.4th at 542. Indeed, adding multiple protections for the unborn child would be a bizarre way of announcing Congress's intent to impose an abortion mandate in emergency rooms.

Yet the administration dismisses this statutory text, asserting that EMTALA's duties run to the mother as the "individual" treated to the exclusion of her "unborn child." U.S.Br.41–43. The text doesn't support that. EMTALA's stabilization obligation applies to both the mother and her unborn child. Consistent with the statutory definition, the administration's Fifth Circuit briefing admitted that an unborn child may independently experience an emergency medical condition. Appellants Br. at 36, *Texas* v. *Becerra*, No. 23-10246 (5th Cir. May 1, 2023). In those circumstances, EMTALA requires stabilizing treatment for the child.

Alternatively, the administration insists that EMTALA vests the mother with the exclusive right to resolve any conflict between treating herself or her "unborn child." U.S.Br.41–43. But EMTALA does not say that. It is silent about abortion or weighing the interests of mother and baby. As the Fifth Circuit recognized in rejecting this argument, "EMTALA leaves the balancing of stabilization to doctors, who must comply with state law." *Becerra*, 89 F.4th at 545 (citing 42 U.S.C. 1395dd(e)(1), (e)(3)(A)). "EMTALA imposes equal stabilization obligations" running to both the mother and the unborn child. *Ibid.*

Amici states supporting the administration say that the mother has this choice because "both the common law and the Constitution protect a competent adult's right to consent to or refuse medical treatment." Calif.Br.16 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990)). But surely that constitutional right does not mean patients can force doctors to perform treatments that state law and medical standards forbid. Idaho.Br.30. Otherwise, patients could simply elect to opt out of state regulations of medicine.

Those same amici states also argue that *Roe* v. *Wade*, 410 U.S. 113 (1973), was law when EMTALA was enacted. Calif.Br.17. But EMTALA's text stands independent of *Roe* and expressly protects unborn children consistent with constitutional state laws that bar elective abortions.

D. EMTALA's "reasonable medical probability" language further supports the application of state-law standards.

The administration and its amici argue that EMTALA's incorporation of "reasonable medical probability" into its definition of stabilization imposes a federal standard of care, see U.S.Br.33, that "*expressly* turns on the exercise of medical judgment." AHA.Br.16. Because Idaho law conflicts "with the judgment of medical professionals providing emergency care," the argument goes, "[i]t is therefore preempted." *Ibid.* This is gravely mistaken.

The EMTALA language on which the federal government relies—"reasonable medical probability"—is a quintessential state-law standard of proof for tort claims,[5] and the use of the term "reasonable" is a hallmark of an objective standard. See *Graham* v. *Connor*, 490 U.S. 386 (1989). EMTALA reinforces that this is a state-law standard by subjecting a provider to penalties only if it "negligently violates" the Act, 42 U.S.C. 1395dd(d)(1)(A)-(B), and to financial liability only if relief is "available … under the law of the State in which the hospital is located." 42 U.S.C. 1395dd(d)(2)(A). And CMS surveyors in EMTALA enforcement must apply "norms of care, diagnosis, and treatment based upon typical patterns of practice *within the geographic area served by the organization*." 42 U.S.C. 1320c-3 (emphasis added).

---

[5] See Robin Kundis Craig, *When Daubert Gets Erie: Medical Certainty and Medical Expert Testimony in Federal Court*, 77 Denv. U.L. Rev. 69, 70 (1999).

The administration's amici cling to a two-word reference to "'national norms'" in 42 U.S.C. 1320c-3. *E.g.*, HHS.Officials.Br.8. But they ignore the local character of the standard, which says "national norms" should be "tak[en] into consideration … where appropriate." 42 U.S.C. 1320c-3. As the circuits uniformly hold, EMTALA does not impose a national standard of care. Idaho.Br.26–27.

E. EMTALA's anti-dumping purpose is consistent with its text.

EMTALA's narrow purpose—anti-patient dumping—is consistent with its narrow text. Idaho.Br.26–27. Historically, there was a "common-law 'no duty' rule, which allowed [hospitals] to refuse treatment to anyone. Hospitals believed indigent patients should receive care through charitable organizations or through uncompensated care provided by hospitals." 121MembersOfCongress.Br.4 (citing U.S. Comm'n on Civ. Rts., *Patient Dumping* 2 (2014)). EMTALA changed that regime by requiring hospital emergency rooms to treat indigent patients when they presented with critical medical conditions.

"It beggars belief that EMTALA, directed as it was at providing emergency care for patients unable to afford treatment, enacted by a bipartisan group of senators and representatives, signed by President Reagan, and with language designed to protect the interests of both mothers and their unborn children, was all along a Trojan horse for mandatory abortion even contrary to state law." AdvancingAmerican Freedom.Br.4–5. There is no evidence Congress intended to "displace the prior state-law regime with a minimum national requirement for emergency care." U.S.Br.37–38.

III. The administration's remaining arguments are unfounded.

The administration's remaining points warrant only brief mention:

1. HHS has *not* "long instructed regulated entities that EMTALA overrides state law" when it comes to *treatment*. Contra U.S.Br.38–39. Where the State Operations Manual warns that "a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation," U.S.Br.39, the Manual is discussing state laws that require "particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals." *State Operations Manual* at 40. That makes sense. Otherwise, states could circumvent EMTALA entirely by directing that every indigent patient presenting at an emergency room be transferred to a particular state hospital. The Manual's warning about state law has nothing to do with standards of practice; it is addressing EMTALA's core anti-dumping function.

Similarly, where the Manual instructs that a "hospital cannot cite State law or practice as the basis for transfer" but must instead satisfy EMTALA, it is referencing hospitals that "have written transfer agreements with facilities capable of handling" "high-risk deliveries or high-risk infants." *Id.* at 61. In such circumstances, the "hospital must still meet the screening, treatment, and transfer requirements" that EMTALA imposes. *Ibid.* Again, the Manual requires no specific treatment and imposes no national standard of care.

2. Next, the administration suggests that under Idaho's reading of EMTALA, a state could prohibit

abortion even to save the life of the mother, and a hospital would be required to abide by that limit. U.S.Br.39; accord U.S.Br.11, 44. Of course, no state has ever adopted such a law, and Idaho particularly has *always* protected maternal life. See also 121MembersOfCongress.Br.12–13 (discussing the difference between medically indicated, maternal-fetal separation and elective induced abortions).

The real problem lies with the administration's reading, under which nothing constrains a doctor's subjective determination that ending an unborn child's life is "required" to "stabilize" an "emergency" mental-health condition—such as severe anxiety or depression. That unregulated judgment would be sufficient to justify a late-term abortion that violates state law. Idaho.Br.30. The administration disregards this example as not required by any "clinical standard." U.S.Br.26 n.5. But EMTALA makes no reference to "clinical standards," and again, the administration has consistently maintained that it is the emergency-room doctor who gets to make that call in his judgment. *E.g.*, Resp. in Opp'n to Appls. for a Stay at 35, *Moyle* v. *United States*, Nos. 23A469 and 23A470 (U.S. Nov. 30, 2023); accord AHA.Br.16–27. That is incompatible with EMTALA's incorporation of state-law standards of care.

3. In a moment of clarity, the administration and its amici concede that EMTALA "does *not* purport to specify the particular treatments necessary to achieve [the stabilization] objective for the wide range of emergency medical conditions it covers." U.S.Br.39 (emphasis added); accord ACOG.Br.13. Yet the administration insists that if "only one treatment would stabilize the patient," such as providing a "chest tube for a collapsed lung," then "that treatment

is required." U.S.Br.39–40. That is not what the statute says. If the procedure to insert a chest tube is not "available" at a small, rural emergency room, EMTALA does not require it. *Supra* Argument II.A.

4. This is what makes EMTALA's singling out of "deliver[y]" as the necessary "stabiliz[ation]" when a pregnant woman is in labor so remarkable. 42 U.S.C. 1395dd(e)(3)(A), (B). It also underscores the importance of caring for the unborn child while indicating that other specific treatments are not required. Idaho.Br.32–33; contra U.S.Br.40.

IV. The district court's injunction is overbroad.

The district court not only misread EMTALA, that court entered an injunction that greatly expanded EMTALA's scope. Idaho.Br.41. The administration does not contest this point, so it stands unrebutted.

* * *

As CMS has explained, EMTALA and its regulations "focus on a hospital's existing capabilities." *Medicare Program*, 59 Fed. Reg. 32,086, 32,100 (June 22, 1994). Those capabilities are necessarily determined and limited by state restrictions on the practice of medicine. If the administration's position is correct, EMTALA preempts not only dozens of state laws regulating abortion but also numerous other state laws regulating the practice of medicine, including those restricting experimental or unethical medications and procedures. Idaho.Br.29–30; Manhattan Institute.Br.7–10. There is no evidence Congress intended that and zero history showing that the executive branch understood EMTALA this way before now. This Court should reject the administration's breathtaking reinterpretation of EMTALA.

CONCLUSION

For these reasons, and those stated in Petitioner's opening brief, the district court's judgment should be reversed.

Respectfully submitted,

JOHN J. BURSCH
ERIN M. HAWLEY
MATTHEW S. BOWMAN
LINCOLN DAVIS WILSON
JACOB P. WARNER
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001

JAMES A. CAMPBELL
JULIE MARIE BLAKE
RORY GRAY
ALLIANCE DEFENDING FREEDOM
44180 Riverside Pkwy
Lansdowne, VA 20176

RAÚL R. LABRADOR
ATTORNEY GENERAL
JOSHUA N. TURNER
Counsel of Record
ALAN M. HURST
JAMES E.M. CRAIG
700 W Jefferson St #210
Boise, ID 83720
josh.turner@ag.idaho.gov
(208) 332-3548

CHARLES J. COOPER
DAVID H. THOMPSON
PETER A. PATTERSON
MEGAN M. WOLD
COOPER & KIRK PLLC
1523 New Hampshire NW
Washington, DC 20036

APRIL 2024