

RAÚL R. LABRADOR
ATTORNEY GENERAL

Joshua N. Turner, ISB #12193
Chief of Constitutional Litigation
and Policy

JAMES E. M. CRAIG, ISB #6365
Chief, Civil Litigation
and Constitutional Defense

BRIAN V. CHURCH, ISB #9391
Lead Deputy Attorney General
Office of the Attorney General
P. O. Box 83720
Boise, ID 83720-0010
Telephone: (208) 334-2400
Facsimile: (208) 854-8073
josh.turner@ag.idaho.gov
james.craig@ag.idaho.gov
brian.church@ag.idaho.gov

Attorneys for Defendant

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

UNITED STATES OF AMERICA

Plaintiff,

v.

STATE OF IDAHO

Defendant.

Case No. 1:22-cv-329-BLW

**EMERGENCY MOTION TO
MODIFY PRELIMINARY
INJUNCTION [Dkt. 95]**

The State of Idaho moves the Court to modify the preliminary injunction previously issued at Docket Entry 95. The Court has jurisdiction to grant such a request under Federal Rule of Civil Procedure 62(d). The accompanying memorandum and declaration of counsel support this motion.

The State seeks an emergency ruling on this motion, and requests a ruling from this Court by Thursday, July 18, 2024. The State has separately filed a Motion for Emergency Ruling and to Shorten Briefing Schedule.

DATED: July 12, 2024.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ Brian V. Church
BRIAN V. CHURCH
Lead Deputy Attorney General

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on July 12, 2024, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

Brian David Netter
brian.netter@usdoj.gov
Daniel Schwei
daniel.s.schwei@usdoj.gov
Julie Straus Harris
julie.strausharris@usdoj.gov
Lisa Newman
lisa.n.newman@usdoj.gov
Anna Lynn Deffebach
anna.l.deffebach@usdoj.gov
Christopher A. Eiswerth
chrisopher.a.eiswerth@usdoj.gov

Emily Nestler
emily.b.nestler@usdoj.gov
Attorneys for Plaintiff United States of America

Monte Neil Stewart
monteneilstewart@gmail.com
Daniel W. Bower
dbower@morrishawhaws.com
Attorney for Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature

Laura Etlinger
laura.etlinger@ag.ny.gov
Attorney for Amici States California, New York, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Washington and Washington, D.C

Jay Alan Sekulow
seulow@aclj.org
Olivia F. Summers
osummers@aclj.org
Laura B. Hernandez
lhernandey@aclj.org
Jordan A. Sekulow
jordansekulow@aclj.org
Stuart J. Roth
stuartroth1@gmail.com
*Attorneys for Amicus Curiae
American Center for Law & Justice*

Wendy Olson
wendy.olson@stoel.com
Jacob M. Roth
jroth@jonesday.com
Amanda K. Rice
arice@jonesday.com
Charlotte H. Taylor
ctaylor@jonesday.com
Attorneys for Amici Curiae, The American Hospital Association and The Association of American Medical Colleges

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srseldon@debevoise.com

Adam B. Aukland-Peck

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Leah S. Martin

lmartin@debevoise.com

Jeffrey B. Dubner

jdubner@democracyforward.org

John T. Lewis

john.t.lewis.iii@usdoj.gov

Maher Mahmood

mmahmood@democracyforward.org

*Attorneys for Amici Curiae American College of
Emergency Physicians, Idaho Chapter of the
American College of Emergency Physicians,
American College of Obstetricians and
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Pediatrics, American Academy of Family
Physicians, American Public Health Association,
and American Medical Association*

/s/ Brian V. Church

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Boise, ID 83720-0010
Telephone: (208) 334-2400
Facsimile: (208) 854-8073
josh.turner@ag.idaho.gov
james.craig@ag.idaho.gov
brian.church@ag.idaho.gov

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UNITED STATES OF AMERICA

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Case No. 1:22-cv-329-BLW

**MEMORANDUM IN SUPPORT
OF EMERGENCY MOTION TO
MODIFY PRELIMINARY
INJUNCTION [Dkt. 95]**

INTRODUCTION

Much has changed since this Court preliminarily enjoined Idaho’s Defense of Life Act in August 2022. Most significantly, the United States has walked back its interpretation of EMTALA so dramatically that a majority of the Supreme Court either believes there is no conflict whatsoever between the two laws or the conflict is so minimal that Idaho’s Defense of Life Act ought to be “almost entirely intact.” Dkt. 165-2 at 15 (Barrett, J., concurring); *see also* Dkt. 165-2 at 40 (Alito, J., dissenting). But it isn’t because this Court has not had the opportunity to modify the scope of the preliminary injunction to catch up with all of the judicial admissions made by the United States. This motion provides that opportunity.

Modification is particularly needed because the United States is sowing confusion. Before the Supreme Court, it made “important” and “critical” judicial admissions that narrowed—dramatically and materially—the scope of any potential conflict between EMTALA and the Defense of Life Act. *Id.* at 12 (Barrett, J., concurring). But in the past few days, the United States has tried to walk away from those judicial admissions. It is warning hospitals of their supposed “obligation” to perform abortions for *all* emergency medical conditions. And it is telling healthcare providers that nothing has changed from its 2022 reinterpretation of EMTALA. The only reasonable interpretation of the United States’ most recent communications regarding EMTALA simply cannot be squared with its judicial admissions. The State of Idaho, thus, respectfully asks this Court to modify the preliminary injunction to hold the United States to the official positions it has taken in this litigation. Those are binding judicial admissions, and the State and the public have a right to see them incorporated into the preliminary injunction.

BACKGROUND

In this case challenging Idaho’s Defense of Life Act, Idaho Code § 18-622, the United States alleges that the Defense of Life Act violates the Supremacy Clause and is preempted as conflicting with the Emergency Medical Treatment and Labor Act (“EMTALA”), 42 U.S.C. § 1395dd. *See generally* Dkt. 1. The federal government brought its suit little more than three weeks before the Defense of Life Act was to take effect, and so the Court set an expedited hearing and the parties submitted expedited briefing. *See* Dkts. 13, 22. Just a day before the law was to take effect, the Court entered a preliminary injunction. Dkt. 95. It enjoined the State from enforcing the Defense of Life Act by

initiating any criminal prosecution against, attempting to suspend or revoke the professional license of, or seeking to impose any other form of liability on, any medical provider or hospital based on their performance of conduct that (1) is defined as an “abortion” under Idaho Code § 18-604(1), but that is necessary to avoid (i) “placing the health of” a pregnant patient “in serious jeopardy”; (ii) a “serious impairment to bodily functions” of the pregnant patient; or (iii) a “serious dysfunction of any bodily organ or part” of the pregnant patient, pursuant to 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii).

Id. at 39.

Although the State moved the Court to reconsider its ruling, including after the Idaho Supreme Court issued *Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 522 P.3d 1132 (2023), this Court denied reconsidering its injunction. Dkt. 135. After a Ninth Circuit appeal was taken, Dkt. 136, that court initially stayed the injunction, but the en banc Ninth Circuit vacated the stay and set the merits of the preliminary injunction appeal for argument before the en banc court. *See* Dkt. 156; *see also* Dkts. 147, 148, 153. Before the Ninth Circuit argument occurred, the Supreme Court of the United States stayed this Court’s injunction and granted

certiorari before judgment. Dkt. 158. The Supreme Court, however, recently vacated its stay and dismissed its writs granting certiorari as improvidently granted. Dkt. 165-2.

Justice Barrett, joined by the Chief Justice and Justice Kavanaugh, explained that the Supreme Court took this action because of the evolution of the case after certiorari was granted. *Id.* at 13 (Barrett, J., concurring). The stay of this Court’s injunction was no longer necessary because of “[t]he dramatic narrowing of the dispute—especially the Government’s position on abortions to address mental health and conscience exemptions for healthcare providers.” *Id.* at 14 (Barrett, J., concurring). Those judicial admissions were in addition to two other judicial admissions made by the federal government. *Id.* at 12 n.* (Barrett, J., concurring).

Yet only days after the Supreme Court relied on the United States’ important judicial admissions, the Department of Health and Human Services and the Centers for Medicare and Medicaid Services issued a letter to hospital and provider associations.¹ The July 2nd letter broadly proclaimed that “EMTALA requires that hospitals offer stabilizing treatment, including abortion care (or transfer, if appropriate) when necessary to stabilize the patient’s emergency medical condition and ensure that the patient’s condition does not materially worsen.” The letter nowhere informs healthcare providers of the material and “critical” judicial admissions the United States made before the Supreme Court, namely, that (1) abortion is not stabilizing treatment for mental health conditions; (2) abortions need not be performed by doctors or hospitals who have conscience objections; (3) EMTALA requires delivery, not abortion, postviability, and (4) EMTALA only requires abortion “in an emergency acute

¹ Press Release, U.S. Dep’t of Health and Hum. Servs., Biden-Harris Administration Reaffirms Commitment to EMTALA Enforcement (July 2, 2024) <https://tinyurl.com/2p9c3vvs>.

medical situation where a woman’s health is in jeopardy if she does not receive an abortion then and there.” Dkt. 165-2 at 12 n.* (Barrett, J., concurring) (cleaned up).

Given the United States’ judicial admissions before the Supreme Court, and to avoid any confusion caused by the July 2nd HHS/CMS letter, the preliminary injunction, as it currently exists, should be modified and narrowed based on those judicial admissions. Two days ago, counsel for the State asked counsel for the United States if the United States would agree to stipulate to modify the scope of the injunction, but the United States declined earlier today. Counsel Decl. Ex. A. Counsel for the State then advised counsel for the United States that it intended to file this motion. *Id.*

LEGAL STANDARD AND JURISDICTION

Federal Rule of Civil Procedure 62(d) permits this Court, while an appeal is pending, to “suspend, modify, restore, or grant an injunction on terms for bond or other terms that secure the opposing party’s rights.” Fed. R. Civ. P. 62(d). Where there has been a significant change in the facts or law, as shown by the party seeking the modification of a preliminary injunction, a court should revise the injunction. *Sharp v. Weston*, 233 F.3d 1166, 1170 (9th Cir. 2000). That is the case here.

ARGUMENT

The United States made four, important judicial admissions before the Supreme Court:

1. Abortion is not stabilizing treatment for mental health conditions, period.
2. Doctors and hospitals do not have to perform or provide abortions to which they object on conscience grounds, period.
3. EMTALA requires delivery, not abortion, postviability.
4. EMTALA only requires abortions for emergency acute medical situations where the woman’s health is in jeopardy if she does not receive an abortion “then and there.”

Dkt. 165-2 at 12–13 and 12 n.* (Barrett, J., concurring (citing United States’ brief before the Supreme Court and oral argument representations)). Those judicial admissions are not reflected in the Court’s preliminary injunction. *See* Dkt. 95 at 39. And the recent HHS/CMS letter fails to acknowledge these judicial admissions and limitations on the scope of EMTALA. This Court should modify the preliminary injunction to accurately reflect the judicial admissions made by the United States and recognized by the Supreme Court.

There can be no doubt that the United States’ judicial admissions are and were significant changes in the facts and law (or at least the fact of the United States’ position on what the law is). The significance of them is inherent in the Supreme Court’s decision to not consider the matter before judgment and to vacate its stay of this Court’s injunction. Dkt. 165-2 at 1. Justice Barrett’s concurrence discussed how the evolution of the case, specifically “the parties’ litigation positions have rendered the scope of the dispute unclear, at best.” *Id.* at 11 (Barrett, J., concurring). And the “dramatic narrowing of the dispute—especially the Government’s position on abortions to address mental health and conscience exemptions for healthcare providers” impacted whether the Court’s injunction should be stayed. *Id.* at 14 (Barrett, J., concurring).

These four judicial admissions bind the United States. Having made these judicial admissions, and having obtained a vacatur of the Supreme Court’s stay of the injunction as a result, the United States is estopped from now denying them. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211, 227 n.8 (2000) (“Judicial estoppel generally prevents a party from prevailing in one phase of a case on an argument and then relying on a contradictory argument to prevail in another phase.”).

The judicial admission regarding mental health is significant because it now materially narrows any alleged conflict between EMTALA and Idaho Code § 18-622. It is also new. In the last reasoned briefing before this Court, the United States’ position was that the Defense of Life Act conflicted with EMTALA as to physicians who performed an abortion “when a patient’s ‘health’ is in ‘serious jeopardy.’” Dkt. 130 at 8. The United States did not limit its position to just physical health. Likewise, in the briefing before the Ninth Circuit, the United States was of the position that “EMTALA requires whatever treatment a provider concludes is medically necessary to stabilize *whatever* emergency condition is present.” Answering Br. at 31, *United States of Am. v. Idaho*, Nos. 23-35440, 23-35450 (Sept. 8, 2023), Dkt. 35 (emphasis added). HHS has long considered an emergency medical condition to include mental health conditions. *E.g.*, 42 C.F.R. § 489.24(b) (defining emergency medical condition as “manifesting itself by acute symptoms of sufficient severity (including severe pain, *psychiatric disturbances* and/or symptoms of substances abuse)”) (emphasis added). But now the United States has conceded that abortion is never a stabilizing treatment for mental health conditions, and so there can be no conflict between the Defense of Life Act and EMTALA as to pregnant women whose emergency conditions are mental health conditions. *See also* Dkt. 165-2 at 45–47 (Alito, J., dissenting). The Court’s injunction currently covers situations where the medical condition is a mental health condition. *See* Dkt. 95 at 39.

The judicial admission regarding conscience protections is also significant. The United States has now taken the position that EMTALA “does not override” the conscience protections recognized in federal law, including the Weldon Amendment, Church Amendment, and Coats-Snowe Amendment (and presumably the Hyde Amendment too). Tr.

Oral Argument at 87–90, *Moyle v. United States*, 144 S. Ct. 2015 (2024) (Nos. 23-726, 23-727).² In fact, the United States acknowledged that federal conscience protections mean that EMTALA does not require abortions even if the entire medical staff of a hospital or the hospital itself objects to providing an abortion. *See id* at 90 (lines 11–18). Yet the United States’ position, articulated clearest before the Ninth Circuit, was that those laws “do not apply on their own terms” and that those laws “reinforce[d]” that abortion was stabilizing treatment. Answering Br. at 56, *Idaho*, Nos. 23-35440, 23-35450, Dkt. 35. And according to the United States then, “EMTALA requires hospitals to offer abortion care when treating physicians deem it necessary.” *Id.* at 28 (heading, emphasis removed). Moreover, to add even further confusion, Secretary Becerra at a recent House Committee on Education and the Workforce hearing, acknowledged physician conscience objections, but was adamant that hospitals lacked such protection and said, “If a healthcare facility is violating the law and not providing the service they’re required to ... they are not entitled to the resources.”³

The preliminary injunction does not account for the United States’ judicial admission that doctors *and* hospitals who have conscience objections are not required to provide abortions. *See* Dkt. 95 at 39. The United States cannot have its cake and eat it too—take one position before the Supreme Court and then take an opposing position in public statements to hospitals and doctors. Modifying the injunction is necessary to ensure the regulated

² A copy of the transcript is also attached as Exhibit B to the Declaration of Counsel.

³ House Committee on Education & the Workforce, *Examining the Policies and Priorities of the Department of Health and Human Services*, at 02:02:08 YouTube (May 15, 2024), <https://www.youtube.com/watch?v=TIMqoOE0YQ0>.

community is protected, Idaho’s law is enjoined no further than necessary, and the United States is held to its judicial admissions.

The judicial admission that abortions are not stabilizing care for postviability emergency medical conditions is also new and significant. Before the Ninth Circuit, the United States clearly articulated its position that the physician chooses “whatever treatment” the physician believes is medically necessary. Answering Br. at 31, *Idaho*, Nos. 23-35440, 23-35450, Dkt. 35 (emphasis added). It has now scrapped that position in part to say that stabilizing treatment for an emergency medical condition that arises postviability is delivery not abortion. *See also* Dkt. 162-5 at 40 (Alito, J., dissenting). Thus, there can now be no conflict between EMTALA and the Defense of Life Act postviability, because the United States has conceded that abortion is *not* required by EMTALA—indeed, delivery is required by EMTALA. The preliminary injunction does not reflect that understanding of EMTALA. *See* Dkt. 95 at 39.

And finally, the “acute medical situation” judicial admission is a significant and new position taken by the United States. For example, in its reply briefing before this Court, the United States’ position was that EMTALA had a “much broader definition of when treatment is required, *i.e.*, for an emergency medical condition *that could result* in ‘placing the health of the individual . . . in serious jeopardy.’” Dkt. 86 at 17 (emphasis added). The United States then defended that position again, arguing that EMTALA may require abortions “when harm is probable.” Dkt. 106 at 24 (citing Dkt. 95 at 21). Its new position is that “EMTALA requires abortion only in an ‘emergency acute medical situation,’ where a woman’s health is in jeopardy if she does not receive an abortion ‘then and there.’” Dkt. 165-2 at 12 n.* (Barrett, J., concurring (citing Tr. of Oral Arg. 79–80)); *see also* Dkt. 165-2 at 41–42 (Alito, J., dissenting).

And yet the preliminary injunction does not reflect EMTALA’s “temporal limitation” that stabilizing treatment is only required for an “acute medical situation” that demands treatment “then and there.” Dkt. 95 at 39. By permitting abortions to merely “avoid” an emergency medical condition, the preliminary injunction is unjustifiably broader and permits prophylactic abortions for distant conditions that the United States now admits EMTALA does not require.⁴

CONCLUSION

Each of the United States’ four judicial admissions represent significant changes of fact or law. The preliminary injunction cannot remain unchanged in light of those admissions. Any potential conflict between the Defense of Life Act and EMTALA is now dramatically narrower, and the preliminary injunction should reflect that. But it doesn’t. It should be modified to account for these judicial admissions.

DATED: July 12, 2024.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ Brian V. Church
BRIAN V. CHURCH
Lead Deputy Attorney General

⁴ The United States did not contest, before the Supreme Court, that the injunction currently exceeds EMTALA’s scope. *See* Reply Br. at 24, *Idaho v. United States of Am.*, No. 23-727, 2024 WL 1657762 (2024); *see also* Opening Br. at 41, *Idaho v. United States of Am.*, No. 23-727, 2024 WL 752335 (2024) (explaining how the Court’s “necessary to avoid an emergency medical condition” standard did not align with EMTALA’s definition of stabilizing treatment).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on July 12, 2024, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

Brian David Netter
brian.netter@usdoj.gov
Daniel Schwei
daniel.s.schwei@usdoj.gov
Julie Straus Harris
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Christopher A. Eiswerth
chrisopher.a.eiswerth@usdoj.gov

Emily Nestler
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Laura B. Hernandez
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Stuart J. Roth
stuartroth1@gmail.com
*Attorneys for Amicus Curiae
American Center for Law & Justice*

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Jacob M. Roth
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Facsimile: (208) 854-8073
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Case No. 1:22-cv-329-BLW

DECLARATION OF COUNSEL

DECLARATION OF COUNSEL

I, BRIAN V. CHURCH, declare as follows:

1. I am a Lead Deputy Attorney General for the State of Idaho, Office of the Attorney General. I am one of the attorneys for the State of Idaho in this proceeding.

2. Attached as **Exhibit A** is a true copy of an email exchange between counsel for the State of Idaho and counsel for the United States.

3. Attached as **Exhibit B** is a true copy of the transcript of the oral argument held before the Supreme Court in the consolidated cases of *Moyle v. United States* and *Idaho v. United States*, Nos. 23-726 and 23-727, sourced from the Supreme Court's website.

Under 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

DATED: July 12, 2024.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ Brian V. Church
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Lead Deputy Attorney General

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chrisopher.a.eiswerth@usdoj.gov

Emily Nestler
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seulow@aclj.org
Olivia F. Summers
osummers@aclj.org
Laura B. Hernandez
lhernandey@aclj.org
Jordan A. Sekulow
jordansekulow@aclj.org
Stuart J. Roth
stuartroth1@gmail.com
*Attorneys for Amicus Curiae
American Center for Law & Justice*

Wendy Olson
wendy.olson@stoel.com
Jacob M. Roth
jroth@jonesday.com
Amanda K. Rice
arice@jonesday.com
Charlotte H. Taylor
ctaylor@jonesday.com
Attorneys for Amici Curiae, The American Hospital Association and The Association of American Medical Colleges

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Jeffrey B. Dubner

jdubner@democracyforward.org

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Maher Mahmood

mmahmood@democracyforward.org

*Attorneys for Amici Curiae American College of
Emergency Physicians, Idaho Chapter of the
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American College of Obstetricians and
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National Medical Association, National Hispanic
Medical Association, American Academy of
Pediatrics, American Academy of Family
Physicians, American Public Health Association,
and American Medical Association*

/s/ Brian V. Church

BRIAN V. CHURCH

Lead Deputy Attorney General

From: [Josh Turner](#)
To: [Newman, Lisa N. \(CIV\)](#)
Cc: [Crown, Nicholas S. \(CIV\)](#); [Crown, Nicholas \(OSG\)](#); [Schwei, Daniel S. \(CIV\)](#); [Eiswerth, Christopher A. \(CIV\)](#); [Deffebach, Anna L. \(CIV\)](#); [Straus Harris, Julie \(CIV\)](#); [Raab, Michael \(CIV\)](#); [Brian Church](#)
Subject: Re: Idaho, Moyle v. United States -- Stipulation to Modify Injunction
Date: Friday, July 12, 2024 3:50:28 PM
Attachments: [image001.png](#)
[image002.png](#)

Thank you for getting back to me, Lisa. We understand the United States' position to be that there is no basis to modify the preliminary injunction and it refuses to stipulate to any modification of the injunction. With apologies for the short notice, later today, the State will be filing a motion with the district court to dissolve the injunction or, alternatively, to modify it. We will represent your objection to that motion.

Separately, we welcome a call at your convenience to discuss next steps in this case more broadly. But as a preview, short of the injunction being dissolved, we do not think that our motion impacts the proceedings in the Ninth Circuit. The district court maintains continuing jurisdiction over the scope of the injunction, and that will be the basis of our motion. Meanwhile, the parties will need to continue to litigate the appeal of the entry of the preliminary injunction in the Ninth Circuit.



Josh Turner | Chief of Constitutional Litigation and Policy
Office of the Attorney General | State of Idaho
O: 208-332-3548 | W: ag.idaho.gov

From: Newman, Lisa N. (CIV) <Lisa.N.Newman@usdoj.gov>
Date: Friday, July 12, 2024 at 8:49 AM
To: Josh Turner <josh.turner@ag.idaho.gov>
Cc: Crown, Nicholas S. (CIV) <Nicholas.S.Crown@usdoj.gov>, Crown, Nicholas (OSG) <Nicholas.Crown@usdoj.gov>, Schwei, Daniel S. (CIV) <Daniel.S.Schwei@usdoj.gov>, Eiswerth, Christopher A. (CIV) <Christopher.A.Eiswerth@usdoj.gov>, Deffebach, Anna L. (CIV) <Anna.L.Deffebach@usdoj.gov>, Straus Harris, Julie (CIV) <Julie.StrausHarris@usdoj.gov>, Raab, Michael (CIV) <Michael.Raab@usdoj.gov>
Subject: RE: Idaho, Moyle v. United States -- Stipulation to Modify Injunction

Hi Josh,

Thank you for the email. We do not see any basis for modifying the preliminary injunction. The injunction is consistent with the government's representations, and the Supreme Court's order vacating the stay contemplates that the current injunction will continue to govern during further proceedings in the lower courts.

Your message suggests that the State and Legislature may be contemplating seeking relief

in the district court. It would be useful to have a conversation about next steps in the case, including what effect a motion to modify would have on the pending preliminary-injunction appeals. If it would be more convenient to speak by phone, please let us know your availability over the next week.

Thank you very much,
Lisa

Lisa Newman

Trial Attorney
United States Department of Justice
Civil Division – Federal Programs Branch
1100 L Street NW
Washington, DC 20005
(202) 514-5578 | lisa.n.newman@usdoj.gov

From: Josh Turner <josh.turner@ag.idaho.gov>
Sent: Wednesday, July 10, 2024 5:06 AM
To: Crown, Nicholas S. (CIV) <Nicholas.S.Crown@usdoj.gov>; Newman, Lisa N. (CIV) <Lisa.N.Newman@usdoj.gov>; Prelogar, Elizabeth B. (OSG) <Elizabeth.B.Prelogar@usdoj.gov>
Subject: [EXTERNAL] Idaho, Moyle v. United States -- Stipulation to Modify Injunction

Counsel,

After the district court entered an injunction in this case, the United States made several important concessions regarding EMTALA’s application and purported conflict with Idaho’s Defense of Life Act that materially impact the scope of the injunction. As Justice Barrett noted, those concessions are:

1. **Mental Health Conditions:** An abortion is not stabilizing treatment for mental health conditions. See *Moyle v. United States*, 2024 WL 3187605, at *5 (U.S. June 27, 2024) (Barrett, J., concurring) (noting that the United States “emphatically disavowed the notion that an abortion is ever required as stabilizing treatment for mental health conditions”).
2. **Conscience Protections:** Individual doctors and hospitals do not have to perform or provide abortions to which they object on conscience grounds. See *Moyle*, 2024 WL 3187605 at *5 (Barrett, J., concurring) (“[F]ederal conscience protections, for both hospitals and individual physicians, apply in the EMTALA context.”).
3. **Delivery not Abortion:** EMTALA requires delivery, not abortion, for emergency medical conditions that arise postviability. See *Moyle*, 2024 WL 3187605 at *5 (Barrett, J., concurring) (noting the United States’ acknowledgement that “EMTALA requires delivery, not abortion.”).

4. **Acute Medical Situation:** EMTALA only requires abortions in the face of an “acute medical situation,” meaning that the abortion is required “then and there.” See *Moyle*, 2024 WL 3187605 at *5 (Barrett, J., concurring) (“EMTALA requires abortion only in an emergency acute medical situation,”—that is “where a woman’s health is in jeopardy if she does not receive an abortion then and there.”).

Based on these concessions—all judicial admissions made on the record and recognized by the Supreme Court—will the United States jointly stipulate to modify the scope of the injunction in the district court? Please let me know the United States’ position by this Friday, and if the United States agrees to so stipulate, I will circulate a proposed stipulation. If I do not hear from you by the end of day on Friday, I will represent that the United States declines to stipulate to modify the injunction.



Josh Turner | Chief of Constitutional Litigation and Policy
Office of the Attorney General | State of Idaho
O: 208-332-3548 | W: ag.idaho.gov

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SUPREME COURT OF THE UNITED STATES

IN THE SUPREME COURT OF THE UNITED STATES

- - - - -

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

v.) No. 23-726

UNITED STATES,)
Respondent.)

- - - - -

IDAHO,)
Petitioner,)

v.) No. 23-727

UNITED STATES,)
Respondent.)

- - - - -

Pages: 1 through 131
Place: Washington, D.C.
Date: April 24, 2024

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1 IN THE SUPREME COURT OF THE UNITED STATES

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4 HOUSE OF REPRESENTATIVES, ET AL.,)

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6 v.) No. 23-726

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8 Respondent.)

9 - - - - -

10 IDAHO,)

11 Petitioner,)

12 v.) No. 23-727

13 UNITED STATES,)

14 Respondent.)

15 - - - - -

16 Washington, D.C.

17 Wednesday, April 24, 2024

18

19 The above-entitled matter came on for

20 oral argument before the Supreme Court of the

21 United States at 10:03 a.m.

22

23

24

25

1 APPEARANCES:

2 JOSHUA N. TURNER, Chief of Constitutional Litigation
3 and Policy, Boise, Idaho; on behalf of the
4 Petitioners.

5 GEN. ELIZABETH B. PRELOGAR, Solicitor General,
6 Department of Justice, Washington, D.C.; on behalf
7 of the Respondent.

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1 P R O C E E D I N G S

2 (10:03 a.m.)

3 CHIEF JUSTICE ROBERTS: We will hear
4 argument this morning in Case 23-726, Moyle
5 versus United States, and the consolidated case.

6 Mr. Turner.

7 ORAL ARGUMENT OF JOSHUA N. TURNER

8 ON BEHALF OF THE PETITIONERS

9 MR. TURNER: Thank you, Mr. Chief
10 Justice, and may it please the Court:

11 When Congress amended the Medicare Act
12 in 1986, it put EMTALA on a centuries' old
13 foundation of state law. States have always
14 been responsible for licensing doctors and
15 setting the scope of their professional
16 practice. Indeed, EMTALA works precisely
17 because states regulate the practice of
18 medicine. And nothing in EMTALA requires
19 doctors to ignore the scope of their license and
20 offer medical treatments that violate state law.

21 Three statutory provisions make this
22 clear. First, Section 1395, the Medicare Act's
23 opening provision, forbids the federal
24 government from controlling the practice of
25 medicine. That's the role of state regulation.

1 Second, subdivision (f) in EMTALA codifies a
2 statutory presumption against preemption of
3 state medical regulations. And, third, EMTALA's
4 stabilization provision is limited to available
5 treatments, which depends on the scope of the
6 hospital staff's medical license. Illegal
7 treatments are not available treatments.

8 Add in this Court's own presumption
9 against preemption of state regulations, combine
10 that with the need for clear and unambiguous
11 Spending Clause conditions, and the
12 administration's reading becomes wholly
13 untenable.

14 The administration's misreading also
15 lacks any limiting principle. If ER doctors can
16 perform whatever treatment they determine is
17 appropriate, then doctors can ignore not only
18 state abortion laws but also state regulations
19 on opioid use and informed consent requirements.
20 That turns the presumption against preemption on
21 its head and leaves emergency rooms unregulated
22 under state law.

23 It's unsurprising that no court has
24 endorsed such an expansive view of EMTALA, and
25 until Dobbs, nor had HHS. Everyone understands

1 that licensing laws limit medical practice.
2 That's why a nurse isn't available to perform
3 open-heart surgery, no matter the need, no
4 matter her knowledge. The answer doesn't change
5 just because we're talking about abortion.

6 The Court should reject the
7 administration's unlimited reading of EMTALA and
8 reverse the district court's judgment.

9 I welcome the Court's questions.

10 JUSTICE THOMAS: The -- normally, when
11 we have a preemption case, there's some
12 relationship between the parties. Is the state
13 being regulated by the federal government under
14 EMTALA, or is the state in -- engaged in some
15 sort of quasi-contractual relationship?

16 MR. TURNER: Yes, Your Honor. In this
17 case, the state -- Idaho, for example, has no
18 state hospitals that participate in -- with
19 emergency rooms in EMTALA. And so, in this
20 case, there isn't even a quasi-relationship.
21 The parties being regulated by EMTALA here are
22 hospitals and doctors.

23 And I think your question is getting
24 at the Armstrong issue, and we think that is a
25 significant question. It wasn't part of the

1 question presented. We think the Indiana amicus
2 brief raises significant questions and deals
3 with that argument well. But the question
4 presented here is one of direct conflict between
5 Idaho's law and EMTALA, and on that question, we
6 don't think it's hard at all.

7 And, Your Honors, going to that direct
8 conflict, I think, if you consider the express
9 limitation within the statute of availability --

10 JUSTICE JACKSON: Well, before we do
11 that, can I just step back and get your
12 understanding of the statute? You made some
13 representations as to how you see it working.
14 And so let me tell you what I think, and then
15 you can tell me whether you agree, disagree, or
16 otherwise.

17 So I think that there are two things
18 that are plain, pretty plain, on the -- the face
19 of this statute. One is that EMTALA is about
20 the provision of stabilizing care for people who
21 are experiencing emergency medical conditions.
22 That's one thing I think the statute is doing.

23 And I also think that it is operating
24 to displace the prerogatives of hospitals or
25 states or whomever with respect to that fairly

1 narrow slice of the healthcare universe. This
2 idea of emergency medical services is like one
3 very minor part or small part of -- of the sort
4 of overall healthcare -- provision of
5 healthcare.

6 So what that means is that when a
7 hospital wants to only provide stabilizing care
8 in emergencies for people who can pay for it,
9 for example, EMTALA says, no, I'm sorry, you
10 have to stabilize anyone who's experiencing an
11 emergency medical condition, or when a hospital
12 wants to provide stabilizing treatments to
13 people who are experiencing only certain kinds
14 of emergency conditions, EMTALA says, no, here's
15 the list of conditions and you have to provide
16 stabilizing care for those people.

17 Similarly, if a state says, look, it's
18 our job to govern all of healthcare in our state
19 and we say that only certain kinds of healthcare
20 can be given to people who are experiencing
21 emergency medical conditions, we don't want
22 whatever treatment, we want only certain kinds
23 of treatment, EMTALA says, no, we are directing
24 that as a matter of federal law, when someone
25 presents with an emergency condition, they have

1 to be assessed and the hospital must do what is
2 -- ever is in its capacity to stabilize them.

3 Is that your understanding of the
4 statute?

5 MR. TURNER: Partially, Your Honor.
6 We agree that EMTALA does impose a federal
7 stabilization requirement, but the question here
8 is what is the content of that stabilization
9 requirement, and for that, you have to reference
10 state law.

11 JUSTICE JACKSON: Okay. Well --

12 JUSTICE KAGAN: If I could just -- I
13 mean, I think what you just said is important
14 because, when you concede that EMTALA imposes a
15 stabilization requirement, it is, this statute,
16 the federal government interfering, if you will,
17 in a state's healthcare choices.

18 So EMTALA is on its face a statute
19 that says it's not all the state's way. There
20 are federal requirements here. There is a
21 requirement to stabilize emergency patients.

22 And you agree with that?

23 MR. TURNER: Yeah, Justice Kagan, we
24 agree that EMTALA -- EMTALA's purpose was narrow
25 to bridge this gap that existed in some states

1 --

2 JUSTICE KAGAN: Okay. So, I mean --

3 MR. TURNER: -- and the failure to
4 treat.

5 JUSTICE KAGAN: -- we can just take
6 off the table this idea that, you know, just
7 because it's a state and it's healthcare, that
8 the federal government has nothing to say about
9 it. The federal government has plenty to say
10 about it in this statute.

11 Now, you're right, now there's a
12 question of what's the content of this
13 stabilization requirement. And as far as I
14 understood your opening remarks, you say, well,
15 this is left to the states.

16 But, if I'm just looking at the
17 statute, the statute tells you what the content
18 of the stabilization requirement is. It's to
19 provide such medical treatment as may be
20 necessary to assure within reasonable
21 probability that no material deterioration of
22 the condition is likely to occur if the person
23 were transferred or didn't get care.

24 So it tells you very clearly it's an
25 objective standard. It's basically it -- you

1 know, it's a standard that clearly has reference
2 to accepted medical practice, not just whatever
3 one doctor happens to think.

4 But it's here is the content of the
5 standard. You have to stabilize. What does
6 that mean? It means to provide the treatment
7 necessary to assure within reasonable medical
8 probability that no material deterioration
9 occurs.

10 MR. TURNER: Yeah, let me respond in
11 two ways. First, the objective standard that
12 you set forth there in that understanding is
13 contrary to the administration's view. They say
14 it is a totally subjective standard and whatever
15 treatment a doctor determines is appropriate,
16 that's --

17 JUSTICE KAGAN: I think that that's
18 not true. I mean, I think you guys can argue
19 about this yourself. But, as I understand the
20 Solicitor General's brief -- and we'll see what
21 the Solicitor General says -- but the Solicitor
22 General says it's not up to every individual
23 doctor. This is a standard that is objective
24 that incorporates accepted medical standards of
25 care.

1 MR. TURNER: Well, and the more
2 fundamental point is the definition that you
3 quoted of stabilizing care in the operative
4 position -- provision in (b)(1) is also
5 textually explicitly qualified by that which is
6 within the staff and facilities available at a
7 hospital. So then we come --

8 JUSTICE JACKSON: Yes. And that's
9 what it means --

10 JUSTICE KAGAN: That's quite right.
11 That's quite right. It says within the staff
12 and facilities available at the hospital. And
13 if you just look at that language, I mean, it's
14 absolutely clear that that's not a reference to
15 what state law involves. The staff and
16 facilities available.

17 If you don't have staff available to
18 provide the medical care, then I guess you can't
19 provide the medical care. If you don't have the
20 facilities available to provide the medical
21 care, then you can't provide the medical care.
22 A transfer has to take place for the good of the
23 patient.

24 MR. TURNER: This is a really
25 important --

1 JUSTICE KAGAN: But this is -- this --
2 the availability here, because -- it's the
3 availability of staff and facilities. It's, you
4 know, do you have the right doctors? Do you
5 have enough doctors? Do you have the right
6 facilities? Or is it better for the patient to
7 transfer them to the hospital a few miles away?

8 MR. TURNER: You're exactly right. Do
9 you have the right doctors? How do you answer
10 that question except by reference to state
11 licensing laws?

12 JUSTICE JACKSON: But you absolutely
13 can't do that. I mean, that's sort of the
14 initial point that I was trying to make, which
15 is that the federal mandate is to provide
16 stabilizing care for emergency conditions,
17 regardless of any other directive that the state
18 has or the hospital has that would prevent that
19 care from being provided. That's -- that's the
20 work of the statute.

21 MR. TURNER: Justice Jackson, that's
22 not even HHS's conclusion. In the state
23 operations manual, which they proffered on page
24 36 of their brief, it defines what makes a staff
25 person available under the statute, and they say

1 it has to --

2 JUSTICE SOTOMAYOR: Counsel, I -- I --
3 this whole issue --

4 JUSTICE JACKSON: And does it say that
5 they're not available if state law doesn't --
6 doesn't allow this procedure?

7 MR. TURNER: It says they are
8 available to the extent they are operating
9 within the scope of their medical license. And
10 that is our argument.

11 They want to now draw it far more
12 narrow and look only at physical availability.
13 We agree that's a component, but there's also a
14 legal availability component here too.

15 JUSTICE SOTOMAYOR: Counsel, the
16 problem we're having right now is that you're
17 sort of putting preemption on its head. The
18 whole purpose of preemption is to say that if
19 the state passes a law that violates federal
20 law, the state law is no longer effective.

21 So there is no state licensing law
22 that would permit you -- permit the state to say
23 don't treat diabetics with insulin. Treat them
24 only with pills, Metformin. And a doctor looks
25 at a juvenile diabetic and says, without

1 insulin, they're going to get seriously ill and
2 the likelihood -- and I don't know what that
3 means under Idaho law, we'll get to that shortly
4 -- because, I don't know, this -- we believe
5 this is a better treatment.

6 MR. TURNER: Yeah.

7 JUSTICE SOTOMAYOR: Federal law would
8 say, you can't do that. Medically accepted --
9 objective medically accepted standards of care
10 require the treatment of diabetics with insulin.
11 The medically accepted obligation of doctors
12 when they have women with certain conditions
13 that may not result in death but more than
14 likely will result in very serious medical
15 conditions, including blindness for some, for
16 others, the loss of organs, for some, chronic
17 blood strokes, Idaho is saying, unless the
18 doctor can say in good faith that this person's
19 death is likely, as opposed to serious illness,
20 they can't perform the abortion.

21 So I don't know your argument about
22 state licensing law because this is what this
23 law does. It tells states, your licensing laws
24 can't take out objective medical conditions that
25 could save a person from serious injury or

1 death.

2 MR. TURNER: Yeah, I think there are
3 two crucial responses to your point. Let me
4 begin with the preemption point.

5 Subdivision (f) and Section 1395
6 actually are telling HHS, the federal
7 government, and courts just the opposite, that
8 you don't --

9 JUSTICE SOTOMAYOR: No, it's saying
10 you can't preempt unless there's a direct
11 conflict. If objective medical care requires
12 you to treat women who are -- who present the
13 potential of serious medical complications and
14 the abortion is the only thing that can prevent
15 that, you have to do it.

16 MR. TURNER: No --

17 JUSTICE SOTOMAYOR: Idaho law says the
18 doctor has to determine not that there's merely
19 a serious medical condition but that the person
20 will die.

21 MR. TURNER: Yeah.

22 JUSTICE SOTOMAYOR: That's a huge
23 difference, counsel.

24 MR. TURNER: Your Honor, we agree that
25 the -- there is daylight between how the

1 administration is reading EMTALA and what
2 Idaho's Defense of Life Act permits. We agree
3 that there's a controversy here. But what I'm
4 saying is that may be --

5 JUSTICE SOTOMAYOR: No, no, no, no,
6 no, there's more than a controversy because what
7 you're saying to us is, if EMTALA doesn't have
8 preemptive force in not just Idaho, it has a
9 saving condition for abortions when it threatens
10 a woman's life.

11 MR. TURNER: Well, when the --

12 JUSTICE SOTOMAYOR: But what you're
13 saying is that no state in the nation -- and
14 there are some right now that don't even have
15 that as an exception to their anti-abortion
16 laws.

17 What you are saying is that there is
18 no federal law on the book that prohibits any
19 state from saying, even if a woman will die, you
20 can't perform an abortion.

21 MR. TURNER: Your Honor, I know of no
22 state that does not include a life-saving
23 exception. But, secondly, the government --

24 JUSTICE SOTOMAYOR: Some have been
25 debating it at least, and if I find one -- but

1 your theory of this case leads to that
2 conclusion.

3 MR. TURNER: I think our point is that
4 EMTALA doesn't address that very --

5 JUSTICE SOTOMAYOR: Does your
6 theory --

7 CHIEF JUSTICE ROBERTS: Could I --
8 could I hear your answer?

9 MR. TURNER: Yeah. In -- the
10 administration's reliance on a standard like
11 best clinical evidence or some national norm, I
12 think that's very fraught because what it really
13 is saying is the text itself doesn't address
14 what stabilizing treatment is required.

15 You go outside the text to
16 professional standards that are floating out
17 there that might change day to day, and that
18 really boils down to a question between a
19 conflict between what the ACOG says and what
20 Idaho law says, and that's not --

21 CHIEF JUSTICE ROBERTS: Thank you.
22 Thank you, counsel.

23 JUSTICE JACKSON: Actually, can I just
24 clarify? Because I'm not sure I understand.

25 You know, sort of looking at this from

1 a broader perspective, it seems to me that
2 EMTALA says you must provide whatever treatment
3 you have the capacity, meaning staff and
4 facilities, to provide to stabilize patients who
5 are experiencing emergency medical conditions.

6 Idaho law seems to say you cannot
7 provide that treatment unless doing so is
8 necessary to prevent a patient's death to the
9 extent the treatment involves abortion.

10 Why is that not a direct conflict?
11 You have "you must" in a certain situation,
12 that's what the federal government is saying,
13 and "you cannot if it involves abortion" says
14 Idaho.

15 MR. TURNER: I think the nurse example
16 really highlights the reason why, because a
17 nurse might be available. The nurse may be --
18 may even think she knows how to, and under the
19 flat "must" provision in EMTALA, the
20 administration's reading would say call her into
21 action, put her into the operating room, and
22 open the patient up.

23 JUSTICE JACKSON: Right. And --

24 MR. TURNER: But that is not --

25 JUSTICE JACKSON: -- and Idaho --

1 JUSTICE KAGAN: Well, that --

2 JUSTICE JACKSON: -- would say no,
3 that's still a conflict. So, fine, let's say
4 the -- let's say the administration's position
5 is that nurse can do it.

6 Are you suggesting that federal law
7 would not take precedence, would not preempt a
8 state law that says no, she can't?

9 MR. TURNER: Well, whether federal law
10 could do that is a different question than
11 whether EMTALA here does do that. And I think
12 the answer is clear that it doesn't.

13 I mean, it's like the Gonzales v.
14 Oregon case, where the Controlled Substances
15 Act, you know, this Court noted that that was --
16 the provisions there rely upon and -- and assume
17 a medical profession being regulated by state
18 police powers. That's the same with EMTALA.
19 EMTALA is a four-page statute. Congress didn't
20 attempt to address the standards of care for
21 every conceivable medical treatment in --

22 JUSTICE KAGAN: It -- it definitely
23 didn't address the standards of care. It did
24 leave that to the medical community. It said,
25 you know, the -- Congress was not going to

1 address every treatment for every condition, but
2 it said you do what is needed to assure
3 non-deterioration.

4 So I guess the question here is, do
5 you concede that with respect to certain medical
6 conditions, an abortion is the standard of care?

7 MR. TURNER: No, because a standard of
8 care under Idaho -- well, I should say, in
9 Idaho, there is a life-saving exception for
10 certain abortions, and that is the standard of
11 care. And the standard of care is necessarily
12 set and determined by state --

13 JUSTICE KAGAN: Well, I think you have
14 to concede that with respect to certain medical
15 conditions abortion is the standard of care
16 because your own statute, as interpreted by your
17 own courts, acknowledges that when a condition
18 gets bad enough such that the woman's life is in
19 peril, then the -- the -- the doctors are
20 supposed to give abortions.

21 MR. TURNER: And --

22 JUSTICE KAGAN: And the reason that
23 that's true is that with respect to certain rare
24 but extremely obviously important conditions and
25 circumstances, abortion is the accepted medical

1 standard of care. Isn't that right?

2 MR. TURNER: Yes, and that -- that was
3 my point, that there is a life-saving exception
4 under Idaho law. Now the question here is --

5 JUSTICE KAGAN: Now -- now the
6 question is, is it also the accepted standard of
7 care when, rather than the woman's life being in
8 peril, the woman's health is in peril?

9 So let's take -- you know, all of
10 these cases are rare, but within these rare
11 cases, there's a significant number where the
12 woman is -- her life is not in peril, but she's
13 going to lose her reproductive organs, she's
14 going to lose the ability to have children in
15 the future, unless an abortion takes place.

16 Now that's the category of cases in
17 which EMTALA says, my gosh, of course, the
18 abortion is necessary to assure that no material
19 deterioration occurs. And yet Idaho says,
20 sorry, no abortion here. And the result is that
21 these patients are now helicoptered out of
22 state.

23 MR. TURNER: Yeah. Your Honor, the --
24 the hypothetical you raise is a very difficult
25 situation, and these situations, I mean, nobody

1 is arguing that they don't raise tough medical
2 questions that implicate deeply theological and
3 moral questions. And Idaho, like 22 other
4 states, and even Congress in EMTALA recognizes
5 that there are two patients to consider in those
6 circumstances. And the two-patient scenario is
7 -- is tough when you have these competing
8 interests.

9 JUSTICE KAGAN: You know, that would
10 be a good response if federal law did not take a
11 position on what you characterize as a tough
12 question, but federal law does take a position
13 on that question. It says that you don't have
14 to wait until the person is on the verge of
15 death. If the woman is going to lose her
16 reproductive organs, that's enough to trigger
17 this duty on the part of the hospital to
18 stabilize the patient. And the way to stabilize
19 patients in these circumstances, all doctors
20 agree.

21 MR. TURNER: And Idaho law does not
22 require that doctors wait until a patient is on
23 the verge of death. There is no imminency
24 requirement. There is no medical certainty
25 requirement. That's --

1 JUSTICE SOTOMAYOR: I'm sorry, answer
2 the following question, and these are
3 hypotheticals that are true.

4 Hold on one second, and you can tell
5 me whether Idaho's exception -- and we still go
6 back to the point that even if Idaho law fully
7 complies with federal law -- you have a pregnant
8 women -- woman who is early into her second
9 tri-semester at 16 weeks, goes to the ER because
10 she felt a gush of fluid leave her body. She
11 was diagnosed with PPROM. The doctors believe
12 that a medical intervention to terminate her
13 pregnancy is needed to reduce the real medical
14 possibility of experiencing sepsis and
15 uncontrolled hemorrhage from the broken sac.

16 This is a story of a real woman. She
17 was discharged in Florida because the fetus
18 still had fetal tones and the hospital said
19 she's not likely to die, but there are going to
20 be serious medical complications. The doctors
21 there refused to treat her because they couldn't
22 say she would die.

23 She was horrified, went home. The
24 next day, she bled. She passed out. Thankfully
25 taken to the hospital. There, she received an

1 abortion because she was about to die.

2 MR. TURNER: Yeah.

3 JUSTICE SOTOMAYOR: What you are
4 telling us, is that a case in which Idaho, the
5 day before, would have said it's okay to have an
6 abortion?

7 MR. TURNER: Under Idaho's life-saving
8 exception, a doctor could in good faith -- if
9 the doctor could in good-faith medical judgment
10 determine --

11 JUSTICE SOTOMAYOR: No. I'm asking
12 you. The Florida doctor said, I can't say she's
13 going to die.

14 MR. TURNER: Yeah. And, Your Honor,
15 my point is that --

16 JUSTICE SOTOMAYOR: If your doctor
17 says, I can't, with a medical certainty, say
18 she's going to die, but I do know she's going to
19 bleed to death if we don't have an abortion, but
20 she's not bleeding yet, so I'm not sure.

21 MR. TURNER: The doctor doesn't need
22 to have medical certainty. The Idaho Supreme
23 Court answered that question --

24 JUSTICE SOTOMAYOR: Counsel, answer
25 yes or no. He doesn't have -- he doesn't --

1 cannot say that there's likely death. He can
2 say there is likely to be a very serious medical
3 condition --

4 MR. TURNER: Yeah. Based on --

5 JUSTICE SOTOMAYOR: -- like a
6 hysterectomy.

7 MR. TURNER: Based on the --

8 JUSTICE SOTOMAYOR: Let me go to
9 another one. Imagine a patient who goes to the
10 ER with PPROM 14 weeks. Again, abortion is the
11 exception. She's up -- she was in and out of the
12 hospital up to 27 weeks. This particular
13 patient, they tried -- had to deliver her baby.
14 The baby died. She had a hysterectomy, and she
15 can no longer have children. All right?

16 You're telling me the doctor there
17 couldn't have done the abortion earlier?

18 MR. TURNER: Again, it goes back to
19 whether a doctor can in good-faith medical
20 judgment make --

21 JUSTICE SOTOMAYOR: That's a lot for
22 the doctor to risk when --

23 MR. TURNER: Well, I think it's
24 protective --

25 JUSTICE SOTOMAYOR: -- when --

1 MR. TURNER: -- of doctor judgment,
2 Your Honor.

3 JUSTICE SOTOMAYOR: -- when Idaho law
4 changed to make the issue whether she's going to
5 die or not or whether she's going to have a
6 serious medical condition. There's a big
7 daylight by your standards, correct?

8 MR. TURNER: It is very case by case.
9 The examples, the prong --

10 JUSTICE SOTOMAYOR: That's the
11 problem, isn't it?

12 JUSTICE BARRETT: Counsel, I'm kind of
13 shocked actually because I thought your own
14 expert had said below that these kinds of cases
15 were covered.

16 MR. TURNER: Yeah.

17 JUSTICE BARRETT: And you're now
18 saying they're not?

19 MR. TURNER: No, I'm not saying that.
20 That's just my point, Your Honor, is that --

21 JUSTICE BARRETT: Well, you're
22 hedging. I mean, Justice Sotomayor is asking
23 you would this be covered or not, and it was my
24 understanding that the legislature's witnesses
25 said that these would be covered.

1 MR. TURNER: Yeah, and those doctors
2 said, if they were exercising their medical
3 judgment, they could in good faith determine
4 that life-saving care was necessary. And that's
5 my point. This is a subjective standard.

6 JUSTICE BARRETT: But some doctors
7 couldn't, is -- some doctors might reach a
8 contrary conclusion, I think --

9 MR. TURNER: Well --

10 JUSTICE BARRETT: -- is what Justice
11 Sotomayor is asking you. So --

12 MR. TURNER: And -- and let me --

13 JUSTICE BARRETT: -- if they reached
14 -- if they reached the conclusion that the
15 legislature's doctors did, would they be
16 prosecuted under Idaho law?

17 MR. TURNER: No. No. If they -- if
18 they reached the conclusion that the -- Dr.
19 Reynolds, Dr. White did, that these were
20 life-saving --

21 JUSTICE BARRETT: What if the
22 prosecutor thought differently? What if the
23 prosecutor thought, well, I don't think any
24 good-faith doctor could draw that conclusion,
25 I'm going to put on my expert?

1 MR. TURNER: And that, Your Honor, is
2 the nature of prosecutorial discretion, and it
3 may result in a -- a case that require --

4 JUSTICE BARRETT: Does Idaho put out
5 any kind of guidance? You know, HHS puts out
6 guidance about what's covered by the law and
7 what's not. Does Idaho?

8 MR. TURNER: There are regulations.
9 DAPA has some regulations. But I think the --
10 the guiding star here is the Planned Parenthood
11 v. Wasden case, which is a lengthy, detailed
12 treatment by the Idaho Supreme Court of this
13 law, and it made clear, the court made clear,
14 that there is no medical certainty requirement.
15 You do not have to wait for the mother to be
16 facing death.

17 JUSTICE JACKSON: Counsel, I don't --

18 CHIEF JUSTICE ROBERTS: Thank you,
19 counsel.

20 Is there -- what happens if a dispute
21 arises with respect to whether or not the doctor
22 was within the confines of Idaho law or wasn't?
23 Is the doctor subjected to review by a medical
24 authority? Exactly how is that evaluated?

25 Because it's an obvious concern. If

1 -- if -- if you have an individual exception for
2 a doctor, and we're having a debate about is
3 that covered by your submission that nothing in
4 Idaho law prohibits complying with EMTALA, I
5 mean, who -- who makes the decision whether or
6 not something's within or without?

7 MR. TURNER: So, I mean, I -- I
8 imagine there are two ways the law can be
9 enforced or at least two. The Board of Medicine
10 has licensing oversight over a doctor. And the
11 Idaho Supreme Court made clear that that
12 doctor's medical judgment is not going to be
13 judged based on an objective standard, what a
14 reasonable doctor would do. That's not the
15 standard.

16 The second way would be if a --

17 CHIEF JUSTICE ROBERTS: Well, what --
18 what is the standard?

19 MR. TURNER: The doctor's good-faith
20 medical judgment, which is subjective.

21 CHIEF JUSTICE ROBERTS: And it's not
22 subject to review by any medical board if
23 there's a complaint against the doctor that --

24 MR. TURNER: Yeah.

25 CHIEF JUSTICE ROBERTS: -- his

1 standards don't comply? Let's say he's the only
2 doctor at the particular emergency room, and he
3 has his own particular standard.

4 MR. TURNER: What -- what the Idaho
5 Supreme Court has said is that you may consider
6 another doctor's opinion only on the question of
7 was it a pretextual medical judgment, not a
8 good-faith one.

9 CHIEF JUSTICE ROBERTS: Thank you.

10 Justice Thomas?

11 Justice Alito?

12 JUSTICE ALITO: Well, I would think
13 that the concept of good-faith medical judgment
14 must take into account some objective standards,
15 but it would leave a certain amount of leeway
16 for an individual doctor. That was how I
17 interpreted what the -- what the state supreme
18 court said.

19 Now you have been presented here today
20 with very quick summaries of cases and asked to
21 provide a snap judgment about what would be
22 appropriate in those particular cases, and,
23 honestly, I think you've hardly been given an
24 opportunity to answer some of the hypotheticals.

25 But would you agree with me that if a

1 medical doctor, who is an expert in this field,
2 were asked, bang, bang, bang, what would you do
3 in these particular circumstances which I am now
4 going to enumerate, the doctor would say: Wait,
5 I don't -- this is not how I practice medicine.
6 I need to know a lot more about the individual
7 case.

8 Would you agree with that?

9 MR. TURNER: Absolutely. And ACOG has
10 -- you know, in the case of PROM, for example,
11 ACOG doesn't just knee-jerk say an abortion is
12 the standard of care. ACOG itself says that
13 expectant management is oftentimes the
14 appropriate standard of care.

15 And so these are difficult questions
16 that turn on the facts that are on the ground
17 between the doctor as he is assessing them with
18 his medical judgment that he's bringing to bear
19 but is also necessarily constrained by Idaho
20 law. Just like every other area of the practice
21 of medicine, state law confines doctor judgment
22 in some ways.

23 JUSTICE ALITO: Thank you.

24 CHIEF JUSTICE ROBERTS: Justice
25 Sotomayor?

1 JUSTICE SOTOMAYOR: There is a
2 difference between stabilizing a person who
3 presents a serious medical condition requiring
4 stabilization than a person who presents with a
5 condition, quoting Idaho's words, where there is
6 a -- poses a great risk of death to the pregnant
7 woman. You agree there's daylight between the
8 two?

9 MR. TURNER: We agree, and I think
10 this is most --

11 JUSTICE SOTOMAYOR: And so there will
12 be some women who present serious medical
13 condition that the federal law would require to
14 be treated who will not be treated under Idaho
15 law?

16 MR. TURNER: No, I disagree with that.
17 Idaho hospitals are treating these women.
18 They're not treating these women with --

19 JUSTICE SOTOMAYOR: Stop.

20 MR. TURNER: -- abortions necessarily,
21 Your Honor, and that's an important point.

22 JUSTICE SOTOMAYOR: And that's my
23 point. Just answer the point, which is they
24 will present with a serious medical condition
25 that doctors in good faith can't say will

1 present death but will present potential loss of
2 life. Those doctors -- potential loss of an
3 organ or serious medical complications for the
4 woman. They can't perform those abortions?

5 MR. TURNER: Yeah. Your Honor, if
6 that hypothetical exists -- and I don't know of
7 a -- a condition that is so certain to result in
8 the loss of an organ but also so certain not to
9 transpire with death. If that condition exists,
10 yes, Idaho law does say that abortions in that
11 case aren't allowed.

12 And I think it's --

13 JUSTICE SOTOMAYOR: All right.
14 That -- let me stop you there because all of
15 your legal theories rely on us holding that
16 federal law doesn't require -- cannot preempt
17 state law on these issues.

18 And so, when I asked you the question
19 if a state defines likelihood of death more
20 stringently than Idaho does, you would say
21 there's no federal law that would prohibit them
22 from doing that?

23 MR. TURNER: Well, I would say that
24 EMTALA does not contain a standard of --

25 JUSTICE SOTOMAYOR: So there is no --

1 no standard of care.

2 In your briefing, you make the SG's
3 position here, and you almost argue that now,
4 that -- that their position that federal law
5 requires stabilizing treatment and not equal
6 treatment of patients, which was a position you
7 took in your brief, you seem to have backed off
8 from it here, you seem to agree that federal law
9 requires some stabilizing condition, whether or
10 not you provide it to other patients.

11 But I have countless briefs that say
12 that both -- that HHS has filed -- that
13 pre-Dobbs, pre-2009, this is not an
14 unprecedented position, that HHS in countless
15 situations cited hospitals for discharging
16 patients who required an abortion as a
17 stabilizing treatment.

18 Congress discussed that topic in the
19 Affordable Care Act and explicitly said that
20 nothing in the Affordable Care Act shall be
21 construed to relieve any healthcare provider
22 from providing emergency services as required by
23 state or federal law.

24 Medical providers have told us that
25 for decades they have understood both federal

1 law and state law to require abortions as
2 stabilizing conditions for people presenting
3 serious medical risk. Lower courts, there's at
4 least cases of lower courts saying you have to
5 provide abortion.

6 So this is not a post-Dobbs
7 unprecedented position by the government.

8 MR. TURNER: It absolutely is. The --
9 in Footnote 2, the administration cites to two
10 spreadsheets that contain 115,000 rows of
11 enforcement instances. The administration --

12 JUSTICE SOTOMAYOR: Counsel --

13 MR. TURNER: -- has not identified a
14 single instance --

15 JUSTICE SOTOMAYOR: -- counsel,
16 pre-Dobbs this wasn't much of a question. But
17 there is HHS guidance and there's at least three
18 cases in which it was invoked. The fact that we
19 didn't have to -- that HHS didn't have to do it
20 much before pre-Dobbs doesn't make their
21 position --

22 MR. TURNER: My point is more --

23 JUSTICE SOTOMAYOR: -- unprecedented.

24 MR. TURNER: My point is more
25 fundamental, Your Honor. It's not just that

1 there are few instances. There are no
2 instances. And not just on the issue of
3 abortion. On any instance where HHS has come in
4 and told a hospital: You have to provide a
5 treatment that is contrary to state law. And
6 this isn't just about abortion. Consider
7 opioids.

8 JUSTICE SOTOMAYOR: Oh, now we're back
9 to that. Okay. Thank you.

10 CHIEF JUSTICE ROBERTS: Justice Kagan?

11 JUSTICE KAGAN: Mr. Turner, practicing
12 medicine is hard, but there are standards of
13 care, aren't there?

14 MR. TURNER: Yes, there are.

15 JUSTICE KAGAN: And one of those
16 standards of care with respect to abortion is
17 that in certain tragic circumstances, as you
18 yourself, as your own state's law acknowledges,
19 where a woman's life is in peril and abortion is
20 the appropriate standard of care, isn't that
21 right?

22 MR. TURNER: That's right.

23 JUSTICE KAGAN: And EMTALA goes
24 further. It says that the appropriate standard
25 of care can't only be about protecting a woman's

1 life. It also has to be about protecting a
2 woman's health. That's what EMTALA says,
3 doesn't it?

4 MR. TURNER: No, it doesn't. It
5 defines "emergency medical condition" with a
6 broader set of triggering conditions, but the --
7 the key question here is what is the
8 stabilization requirement, and that is qualified
9 by the availability term.

10 JUSTICE KAGAN: The -- the
11 stabilization requirement is -- is written in
12 terms of making sure that a transfer would not
13 result in a material deterioration as to the
14 emergency condition. Nothing about has to be at
15 death's door, right?

16 MR. TURNER: I think that's right,
17 yeah.

18 JUSTICE KAGAN: And there is a
19 standard of care with respect to that on
20 abortions too, right? If a woman is going to
21 lose her reproductive organs unless she has an
22 abortion, which happens in certain tragic
23 circumstances, a doctor is supposed to provide
24 an abortion, isn't that right?

25 MR. TURNER: EMTALA doesn't contain

1 any standard of care. I don't know where the
2 administration is drawing --

3 JUSTICE KAGAN: Do you -- do you
4 dispute that there's a medical standard of care
5 that when a woman is about to lose her
6 reproductive organs unless she has an abortion,
7 that -- that doctors would not say that an
8 abortion is the appropriate standard of care in
9 that situation?

10 MR. TURNER: Your Honor, what I
11 dispute is that there's a national uniform
12 standard of care that requires a top-down
13 approach in all states. Idaho has set its own
14 standard of care, and it has drawn the line on a
15 difficult question.

16 And it's inconceivable to me to think
17 that Congress attempted to answer this very
18 fraught complicated question in a four-page --
19 in four pages of the U.S. Code. It did not --

20 JUSTICE KAGAN: Congress said as to
21 any condition in the world, if an emergency
22 patient comes in, you're supposed to provide the
23 emergency care that will ensure that that
24 patient does not see a material deterioration in
25 their health.

1 MR. TURNER: And always within the --

2 JUSTICE KAGAN: That's what Congress
3 said. And the abortion exceptionalism here is
4 on the part of the state saying we're going to
5 accept that with respect to every other
6 condition but not with respect to abortion --

7 MR. TURNER: Abortion isn't
8 exceptional.

9 JUSTICE KAGAN: -- where we will not
10 comply with the standard of care that doctors
11 have accepted.

12 MR. TURNER: Your Honor, abortion
13 isn't exceptional. There are numerous cases
14 where states intervene and say the standard of
15 care in this circumstance for this condition is
16 X, not Y. Opioids, for example.

17 In New Jersey, a doctor cannot
18 stabilize chronic pain with more than a five-day
19 supply of opioids. In Pennsylvania, it can be
20 seven. In other states, there is no limit.
21 Their reading of EMTALA requires that those
22 limitations get wiped out and you impose a
23 national standard.

24 There are numerous other instances
25 where states are coming in and saying, in our

1 state, the practice of medicine must conform to
2 this standard. And Idaho has done that with
3 abortion. It's done it with opioids. It's done
4 it with marijuana use. There are countless
5 examples, Your Honor.

6 JUSTICE KAGAN: And your theory --
7 although the Supreme Court has narrowed the
8 reach of your statute, your theory would apply
9 even if it hadn't? I mean, it would apply to
10 ectopic pregnancies. It would apply even if
11 there were not a death exception.

12 I mean, all of your theory would apply
13 no matter what, really, Idaho did, wouldn't it?

14 MR. TURNER: If -- yeah, I think the
15 answer is EMTALA doesn't speak to that, but
16 there are other background principles and
17 limitations like rational basis review, Justice
18 Rehnquist, the Chief Justice recognized --

19 JUSTICE KAGAN: But your theory of
20 EMTALA is that EMTALA preempts none of it? That
21 a state tomorrow could say even if death is
22 around the corner, a state tomorrow could say
23 even if there's an ectopic pregnancy, that still
24 that's a -- that's a -- a choice of the state
25 and EMTALA has nothing to say about that?

1 MR. TURNER: Yeah. And that
2 understanding is a humble one with respect to
3 the federalism role of states as the primary
4 care providers for their citizens, not the
5 federal government.

6 JUSTICE KAGAN: It may be too humble
7 for women's health, you know? Okay. Thank you.

8 CHIEF JUSTICE ROBERTS: Justice
9 Gorsuch?

10 JUSTICE GORSUCH: I just wanted to
11 understand some of your responses or efforts to
12 respond to some of the questions that we've
13 heard today.

14 As I read your briefs, you thought --
15 Idaho thinks that in cases of molar and ectopic
16 pregnancies, for example, that -- that an
17 abortion is acceptable.

18 MR. TURNER: Correct, Your Honor.

19 JUSTICE GORSUCH: And the example of
20 someone who isn't immediately going to die but
21 may at some point in the future, that that would
22 be acceptable?

23 MR. TURNER: It goes back to the
24 good-faith medical standard, but, yes, if the
25 doctor should determine -- cannot determine in

1 good faith that death is going to afflict that
2 woman, then no --

3 JUSTICE GORSUCH: So it doesn't matter
4 whether it happens tomorrow or next week or a
5 month from now?

6 MR. TURNER: There is no imminency
7 requirement. This whole notion of delayed care
8 is just not consistent with the Idaho Supreme
9 Court's reading of the statute and what the
10 statute says.

11 JUSTICE GORSUCH: And the good faith,
12 as I read the Idaho Supreme Court opinion, that
13 -- that controls? That's the end of it?

14 MR. TURNER: Absolutely, it is.

15 JUSTICE GORSUCH: All right. And then
16 what do we do with EMTALA's definition of
17 "individual" to include both the woman and, as
18 the statute says, the unborn child?

19 MR. TURNER: Yeah. It -- you know,
20 we're not saying, Your Honor, that EMTALA
21 prohibits abortions. So, for example, in
22 California, stabilizing treatment may involve
23 abortions consistent with what that state law
24 allows its doctors to perform.

25 But I think our point with the unborn

1 child amendment in 1989 is that it would be a
2 very strange thing for Congress to expressly
3 amend EMTALA to require care for unborn
4 children, and it's not just when the child --
5 when the mother is experiencing active labor.
6 The definition of "emergency medical condition"
7 requires care when the child itself has an
8 emergency medical condition regardless of what's
9 going on with the mother.

10 And so it would be a strange thing for
11 Congress to have regard for the unborn child and
12 yet also be mandating termination of unborn
13 children.

14 JUSTICE GORSUCH: Thank you.

15 CHIEF JUSTICE ROBERTS: Justice
16 Kavanaugh?

17 JUSTICE KAVANAUGH: I just want to
18 focus on the actual dispute as it exists now,
19 today, between the government's view of EMTALA
20 and Idaho law, because Idaho law has changed
21 since the time of the district court's
22 injunction both with the Idaho Supreme Court and
23 with a clarifying change by the Idaho
24 legislature.

25 You say in your reply brief, and so

1 too the -- the Moyle reply brief says, that for
2 each of the conditions identified by the
3 Solicitor General where, under their view of
4 EMTALA, an abortion must be available, you say
5 in the reply brief that Idaho law, in fact,
6 allows an abortion in each of those
7 circumstances, and you go through them on pages
8 8 and 9 of the reply brief, each of the
9 conditions.

10 Is there any condition that you're
11 aware of where the Solicitor General says EMTALA
12 requires that an abortion be available in an
13 emergency circumstance where Idaho law, as
14 currently stated, does not?

15 MR. TURNER: So, certainly, the
16 administration maintains that there is such
17 conditions. The ones they identify in the
18 affidavits --

19 JUSTICE KAVANAUGH: What is your --
20 what is your view?

21 MR. TURNER: And my view is that
22 yes -- and I'm going to reference Footnote 5
23 from the gray brief -- the mental health
24 condition situation. The administration says
25 that's not on the table. That's not a scenario

1 where abortion is the only stabilizing care
2 required. And I'm not sure where that construct
3 of "only stabilizing care" comes from because,
4 under their view, it's the doctor's
5 determination that controls, not this imposed
6 "only" requirement.

7 But be that as it may, the American
8 Psychiatric Association -- and so I'm taking
9 General Prelogar up on her offer in Footnote 5
10 that there are no professional organizations
11 that set abortion as a standard of care.

12 The American Psychiatric Association,
13 in a 2023 position paper, says that abortions
14 are imperative for mental health conditions.
15 That sounds like a necessity to me. And I don't
16 know how, if a woman presents at seven months
17 pregnant in an Idaho emergency room and says,
18 I'm experiencing severe depression from this
19 pregnancy, I'm having suicidal ideation from
20 carrying this pregnancy forth, that that
21 wouldn't under the administration's reading be
22 the only stabilizing care.

23 JUSTICE KAVANAUGH: So you think the
24 Ninth Circuit panel, when it said every
25 circumstance described by the administration's

1 declarations involved life-threatening
2 circumstances under which Idaho law would allow
3 an abortion, is what the Ninth Circuit panel
4 said?

5 MR. TURNER: We agree with that
6 because the conditions identified in the
7 affidavits were all conditions that would fit
8 under the life-saving exception, and that's
9 telling because, you know, these doctors, when
10 put under oath in an affidavit, couldn't come up
11 with any of these harrowing circumstances. They
12 identified other ones.

13 But I think what the government
14 doesn't want to talk about, again, is the mental
15 health exception here. That is -- I just don't
16 know how you can read their understanding and --

17 JUSTICE KAVANAUGH: Well, I'm just
18 trying to figure out is there really a -- other
19 than the mental health, which we haven't had a
20 lot of briefing about, is there any other
21 condition identified by the Solicitor General
22 where you think Idaho law would not allow a
23 physician in his or her good-faith judgment to
24 perform an emergency abortion?

25 MR. TURNER: Not in their affidavits.

1 They maintain nonetheless that when you compare
2 the definition of what an emergency medical
3 condition is, it is broader than the definition
4 of the life-saving exception in Idaho law. And
5 so they present this --

6 JUSTICE KAVANAUGH: Well, that's what
7 they -- they say, but then, when we get down to
8 the actual conditions that are listed, the
9 examples -- and Justice Sotomayor was going
10 through some of those -- you have said in your
11 brief at least that each of the conditions
12 identified by the government, actually, Idaho
13 law allows an emergency abortion.

14 MR. TURNER: And I agree, and I think
15 the injunction here is also --

16 JUSTICE KAVANAUGH: Well, what's --
17 what -- what does that mean for what we're
18 deciding here --

19 MR. TURNER: Well, what it means for
20 Idaho --

21 JUSTICE KAVANAUGH: -- if Idaho -- if
22 Idaho law allows an abortion in each of the
23 emergency circumstances that is identified by
24 the government as EMTALA mandating that it be
25 allowed?

1 MR. TURNER: I'll say two things. I
2 mean, the real practical first response is that
3 Idaho's under an injunction that includes an
4 incredibly broad requirement that preempts state
5 law --

6 JUSTICE KAVANAUGH: Right. I -- I
7 understand that. And that may mean that there
8 shouldn't be an injunction.

9 MR. TURNER: Yeah.

10 JUSTICE KAVANAUGH: I take your point
11 on that. What's your second?

12 MR. TURNER: My second point, Your
13 Honor, is I don't know how this Court can make
14 the determination on whether there are any
15 real-world conditions without first answering
16 the statutory interpretation question of what
17 EMTALA's stabilization requirement actually
18 requires. That has to be addressed, and it has
19 to be addressed not only because that's where
20 the direct --

21 JUSTICE KAVANAUGH: Well, I was just
22 picking up on your reply brief. You're the one
23 who said it in your reply brief --

24 MR. TURNER: Yeah.

25 JUSTICE KAVANAUGH: -- that there's

1 actually no -- no real daylight here in terms of
2 the conditions. So I'm just picking up on what
3 you all -- you all said.

4 MR. TURNER: Yeah. I understand, Your
5 Honor.

6 JUSTICE KAVANAUGH: Thank you.

7 CHIEF JUSTICE ROBERTS: Justice
8 Barrett?

9 JUSTICE BARRETT: I guess I don't
10 really understand why we have to address the
11 stabilizing condition if what you say is that
12 nobody has been able to identify a conflict.

13 And on the mental health thing, the SG
14 says -- I just picked it up to check Footnote
15 5 -- "Idaho badly errs in asserting that
16 construing EMTALA according to its terms would
17 turn emergency rooms into federal abortion
18 enclaves by allowing pregnancy termination for
19 mental health concerns."

20 So, if that's the only space that you
21 can identify where Idaho would preclude an
22 abortion and EMTALA would require one, and the
23 -- the government is saying no, that's not so,
24 what's the conflict?

25 MR. TURNER: Well, Your Honor, I mean,

1 of course, we think we win whether you find no
2 factual conflict and, therefore, the injunction
3 had to go away.

4 JUSTICE BARRETT: But why? Why are
5 you here? I mean, you know, the government says
6 -- you say --

7 MR. TURNER: Well, they sued us, Your
8 Honor.

9 JUSTICE BARRETT: Well, hold on a
10 second. You're here because there's an
11 injunction precluding you from enforcing your
12 law. And if your law can fully operate because
13 EMTALA doesn't curb Idaho's authority to enforce
14 its law, what's --

15 MR. TURNER: Well, it can't under the
16 injunction because the injunction says that
17 Idaho's law is preempted in an incredibly broad
18 range of circumstances to avoid --

19 JUSTICE BARRETT: As -- as it
20 conflicts with EMTALA, I thought.

21 MR. TURNER: It -- it -- it is much
22 broader than that. It -- and this was based on
23 the proffered injunction by the administration
24 to avoid an emergency medical condition, not in
25 the face of an emergency medical condition.

1 So what that means is Idaho's law
2 can't even operate when a doctor determines that
3 a condition might need to be avoided that hasn't
4 yet presented itself. That's far broader than
5 the emergency medical condition and
6 stabilization requirement under EMTALA because
7 the stabilization requirement under EMTALA is
8 only triggered when there has been a
9 determination that a --

10 JUSTICE BARRETT: Okay. Well, I -- I
11 would like to hear the Solicitor General's
12 response to that.

13 But let me just ask you one other
14 thing about the mental health consideration
15 because I can -- I can understand Idaho's point
16 that a mental health exception would be far
17 broader than Idaho law and had the potential to
18 expand the availability of abortion far beyond
19 what Idaho law permits.

20 But the stabilization requirement only
21 exists up until transfer, right, until transfer
22 is possible? So it's hard for me to see how,
23 with a mental health condition, that couldn't be
24 stabilized before needing to transfer, right?

25 At that point, the Idaho hospital

1 could say: Well, you're -- you're stable,
2 you're not immediately going to be suicidal,
3 we'll leave you in the care of, you know, a
4 parent or a partner who will then seek
5 appropriate treatment.

6 MR. TURNER: Well, that flexible view
7 of stabilization is very different than the
8 government's very rigid view of stabilization,
9 which is, if an emergency medical condition
10 calls for an abortion, it's got to be provided
11 right there and then if it's available in this
12 very limited sense. And so the stabilization
13 continuum that you're talking about, I agree,
14 that's built into EMTALA because --

15 JUSTICE BARRETT: The statute says
16 until transfer is possible.

17 MR. TURNER: Well, the -- the transfer
18 provision kicks in if a hospital is unable to
19 stabilize a condition. And so, if a patient
20 presents at a hospital and that hospital has the
21 capability, the availability to stabilize the
22 condition, in the case of mental health, I
23 invite General Prelogar to come up here and tell
24 you that I've got it all wrong and that, you
25 know, the mother that I described would not need

1 to receive stabilization in that circumstance
2 and instead would be transferred to a
3 psychiatric hospital or something and that
4 wouldn't constitute dumping under their reading.

5 I just don't see how that comports
6 with everything they've said about the rigid
7 view of stabilization that if a condition calls
8 for it and a hospital can do it, it's got to be
9 done there and then.

10 JUSTICE BARRETT: Does Idaho have any
11 kind of conscience exemption for doctors under
12 state law?

13 MR. TURNER: It does. And there are
14 federal conscience protections as well. And I
15 think that is a key point here, Your Honor.

16 The administration told this Court in
17 the FDA case that individual doctors are never
18 required to perform an abortion from what I
19 could tell, but that doesn't extend to
20 hospitals. And so, in the case of Catholic
21 hospitals -- and there are hundreds of them
22 treating millions of patients every year --
23 under the administration's reading, Catholic
24 hospitals who faithfully adhere to the ethical
25 and religious directives are now required to

1 perform abortions.

2 JUSTICE BARRETT: Is that because no
3 federal conscience exemption applies?

4 MR. TURNER: I don't know why they say
5 that's the line that they draw between
6 individual doctors and religious institutions
7 because Coats-Snowe on its face seems to cover
8 both.

9 JUSTICE BARRETT: Okay. Thank you.

10 CHIEF JUSTICE ROBERTS: Justice
11 Jackson?

12 JUSTICE JACKSON: I'm really surprised
13 to hear you say that Idaho law permits
14 everything that the federal law requires. So I
15 just -- I'm trying to understand that because it
16 seems to me that if that's the case, then why
17 couldn't emergency room physicians in Idaho just
18 ignore Idaho law and follow the federal
19 standard?

20 I mean, if -- if -- if the state is
21 doing exactly what the -- what the federal law
22 says is required, if it's okay by Idaho, then,
23 fine, we set Idaho aside. We do what the
24 federal law says, and we all go home.

25 MR. TURNER: Well, I mean, our

1 reading, of course, is that there is no
2 conflict. And so as doctors aren't having to
3 make this choice of do I follow EMTALA or do I
4 follow --

5 JUSTICE JACKSON: So your
6 representation on the -- on behalf of Idaho is
7 that if a -- an emergency room physician in
8 Idaho follows EMTALA in terms of when an
9 abortion is required to stabilize a patient,
10 they will be complying with Idaho law such that
11 there's going to be no prosecution and no
12 problem?

13 MR. TURNER: Yes, because they have to
14 comply with Idaho law to comply with EMTALA.

15 JUSTICE JACKSON: No, no. I'm asking
16 you, if they -- if they comply with EMTALA, will
17 they necessarily have satisfied the requirements
18 of Idaho law? Because that's what you seemed to
19 say in response to Justice Kavanaugh and in
20 response to Justice Barrett. So I just want to
21 make clear if that's the position of the State.

22 MR. TURNER: EMTALA's stable -- the
23 scope of EMTALA's stabilization requirement is
24 necessarily determined by Idaho law in this
25 case. So --

1 JUSTICE JACKSON: No. You're saying,
2 if they follow Idaho law, then they will be
3 following EMTALA law.

4 MR. TURNER: Well, I -- it's both.

5 JUSTICE JACKSON: I'd like for you to
6 -- I'd like for you to --

7 MR. TURNER: I think it's both, Your
8 Honor.

9 JUSTICE JACKSON: No, it's not. I'd
10 like for you to entertain the other possibility.
11 You seem to be saying every situation in which
12 the United States says here's a stabilization
13 situation that the United States would say the
14 person has to have an abortion, the physicians
15 would say we're following EMTALA and abortion is
16 required, I thought you said in response to
17 Justice Kavanaugh, yes, Idaho law would also say
18 that's a situation in which an abortion is
19 allowed.

20 If that's the case, then it seems to
21 me there is no daylight, there's no conflict, as
22 you've said, but it's because Idaho law is in
23 full compliance with what the federal law is
24 saying. We're getting it wrong, you're saying.
25 Like this death thing, that's not what we really

1 mean. What we mean is whenever it's necessary
2 to stabilize a patient who is experiencing
3 deterioration, as federal law requires.

4 MR. TURNER: No. I -- I think I
5 understand the point that you're making. And
6 the best way that I can think of it, Your Honor,
7 is that EMTALA's stabilization requirement
8 requires medical judgment to determine what is
9 the appropriate stabilizing treatment, right?

10 And how does a doctor exercise medical
11 judgment? Well, his training, his experience,
12 perhaps reference to professional standards of
13 care that are national, but --

14 JUSTICE JACKSON: How about -- how
15 about --

16 MR. TURNER: -- necessarily state law
17 standards as well.

18 JUSTICE JACKSON: -- how about --
19 that's not just something you're sort of coming
20 up with. I mean, as Justice Kagan said at the
21 beginning, EMTALA tells the doctor how he's
22 supposed to decide it in this particular
23 circumstance with reference to the medical
24 standards of care concerning when a patient is
25 deteriorating in an emergency condition

1 situation.

2 MR. TURNER: Yeah, EMTALA --

3 JUSTICE JACKSON: So, if that's the
4 standard in EMTALA, are you representing that
5 that is exactly what Idaho is saying so that all
6 the doctors need to do is follow EMTALA and
7 they'll be fine under Idaho law?

8 MR. TURNER: Well, of course, we're
9 saying that Idaho doctors need to comply with
10 EMTALA. The question is how do doctors comply
11 with EMTALA, and EMTALA --

12 JUSTICE JACKSON: Let me ask you
13 another question. Let me -- I -- I think I
14 understand your point. You're saying Idaho is
15 actually -- or could actually be requiring more
16 and the federal law has to make them do what
17 Idaho says.

18 MR. TURNER: Well, and it's important
19 that --

20 JUSTICE JACKSON: Yeah.

21 MR. TURNER: -- EMTALA itself, it
22 codifies this presumption of a backdrop of state
23 law. There are background principles here, and
24 that's what --

25 JUSTICE JACKSON: All right. Let me

1 explore that with you for just a second.

2 I -- I had thought that this case was
3 about preemption and that the entirety of our
4 preemption jurisprudence is the notion that the
5 federal government in certain circumstances can
6 make policy pronouncements that differ from what
7 the state may want or what anybody else may
8 want, and the Supremacy Clause says that what
9 the federal government says takes precedent.

10 So you've been saying over and over
11 again Idaho is, you know, a state and we have
12 healthcare policy choices and we've made --
13 we've set a standard of care in this situation.

14 All that's true. But the question is
15 to what extent can the federal government say:
16 No, in this situation, our standard is going to
17 apply?

18 MR. TURNER: And --

19 JUSTICE JACKSON: That's what the
20 government is saying, and I don't understand
21 how, consistent with our preemption
22 jurisprudence, you can be saying otherwise.

23 MR. TURNER: Yeah, if I can put a
24 finer point on it. I don't think it's -- the
25 question is necessarily what can Congress do but

1 what did Congress do here with EMTALA, and --

2 JUSTICE JACKSON: All right. So what
3 did it do here?

4 MR. TURNER: Yeah. It started, it
5 opened the Medicare Act by saying the federal
6 government shall not control the practice of
7 medicine. And then, in EMTALA itself, it says
8 state laws are not preempted. And then, when it
9 -- and then, when you get to --

10 JUSTICE JACKSON: State laws are not
11 preempted to the extent --

12 MR. TURNER: Of a direct --

13 JUSTICE JACKSON: -- or are only
14 preempted to the extent they --

15 MR. TURNER: -- of a direct conflict.

16 JUSTICE JACKSON: -- of a direct
17 conflict. And so now we are -- we are
18 identifying a direct conflict. So why --

19 MR. TURNER: Well --

20 JUSTICE JACKSON: -- is preemption not
21 working there?

22 MR. TURNER: And -- and whether
23 there's a direct conflict based on this Court's
24 longstanding precedent includes clear statement
25 canons that -- we think we win on the text. Let

1 me be very clear. The text to us is very clear,
2 it's an easy question. But the government's got
3 to come -- overcome a lot of other hurdles, one
4 being --

5 JUSTICE JACKSON: I hear you saying
6 two things, that we're -- there's not a direct
7 conflict because everything we -- the federal
8 government requires we allow, which the amici,
9 Physicians For Human Rights, who have looked at
10 Idaho's law and says it prevents a lot of things
11 in circumstances in which the federal government
12 would require them, they disagree with you on
13 the facts, but, anyway, you say no conflict
14 because we actually are doing exactly what -- or
15 allowing exactly what the federal government
16 allows.

17 And you say no conflict because the
18 federal government in this situation wanted the
19 states to be able to set the standards. And I
20 guess I don't understand how that's even
21 conceivable, given this standard, given this
22 statute --

23 MR. TURNER: Yeah.

24 JUSTICE JACKSON: -- that is coming in
25 to displace state prerogatives.

1 MR. TURNER: And if I can't convince
2 you on the second, let me add a third.

3 JUSTICE JACKSON: Yes, please.

4 MR. TURNER: And there the clear
5 statement canon. So the Spending Clause
6 condition nature of this requires Congress to
7 speak clearly and unequivocally that it is
8 imposing a abortion mandate. It -- that's not
9 here in the statute.

10 And, secondly, this Court's
11 presumption --

12 JUSTICE JACKSON: But doesn't that
13 make abortion different? I mean, what do you
14 mean? They say provide whatever is necessary to
15 stabilize. So you're saying they'd have to say
16 provide whatever is necessary, including
17 abortion? That's the only way that is taken
18 account of here?

19 MR. TURNER: No, what I'm saying is,
20 when we -- when we go and look at the phrase
21 "available" and what it means, the government --
22 the administration is saying, well, they're
23 adding this tag that says consistent with state
24 law.

25 And we're saying no, under the clear

1 statement canon, it's a presumption against
2 preemption. And what the government actually --
3 what Congress would need to do if it wanted to
4 preempt this very traditional area of state law
5 is to put a tag regardless of state law, and
6 that is missing.

7 JUSTICE JACKSON thank you.

8 CHIEF JUSTICE ROBERTS: Thank you,
9 counsel.

10 General Prelogar.

11 ORAL ARGUMENT OF GEN. ELIZABETH B. PRELOGAR

12 ON BEHALF OF THE RESPONDENT

13 GENERAL PRELOGAR: Mr. Chief Justice,
14 and may it please the Court:

15 EMTALA's promise is simple but
16 profound. No one who comes to an emergency room
17 in need of urgent treatment should be denied
18 necessary stabilizing care. This case is about
19 how that guarantee applies to pregnant women in
20 medical crisis.

21 In some tragic cases, women suffer
22 emergency complications that make continuing
23 their pregnancy a grave threat to their lives or
24 their health. A woman whose amniotic sac has
25 ruptured prematurely, for example, needs

1 immediate treatment to avoid a serious risk of
2 infection that could cascade into sepsis and the
3 risk of hysterectomy. A woman with severe
4 preeclampsia can face a high risk of kidney
5 failure that could require life-long dialysis.

6 In cases like these, where there is no
7 other way to stabilize the woman's medical
8 condition and prevent her from deteriorating,
9 EMTALA's plain text requires that she be offered
10 pregnancy termination as the necessary
11 treatment. And that's how this law has been
12 understood and applied for decades.

13 That usually poses no conflict with
14 state law. Even states that have sharply
15 restricted access to abortion after Dobbs
16 generally allow exceptions to safeguard the
17 mother's health. But Idaho makes termination a
18 felony punishable by years of imprisonment
19 unless it's necessary to prevent the woman's
20 death.

21 I think I understood my friend today
22 to acknowledge several times that there is
23 daylight between that standard and the necessary
24 stabilizing treatment that EMTALA would require.
25 And the Idaho Supreme Court recognized the same

1 thing when it specifically contrasted the
2 "necessary to prevent death" exception and said
3 it was materially narrower than a prior Idaho
4 law that had a health exception that tracked
5 EMTALA.

6 The situation on the ground in Idaho
7 is showing the devastating consequences of that
8 gap. Today, doctors in Idaho and the women in
9 Idaho are in an impossible position. If a woman
10 comes to an emergency room facing a grave threat
11 to her health, but she isn't yet facing death,
12 doctors either have to delay treatment and allow
13 her condition to material -- to materially
14 deteriorate, or they're airlifting her out of
15 the state so she can get the emergency care that
16 she needs. One hospital system in Idaho says
17 that right now it's having to transfer pregnant
18 women in medical crisis out of the state about
19 once every other week. That's untenable, and
20 EMTALA does not countenance it.

21 None of Petitioners' interpretations
22 fit with the text, and so they have tried to
23 make this case be about the broader debate for
24 access to abortion in cases of unwanted
25 pregnancy. But that's not what this case is

1 about at all. Idaho's ban on abortion is
2 enforceable in virtually all of its
3 applications, but in the narrow circumstances
4 involving grave medical emergencies, Idaho
5 cannot criminalize the essential care that
6 EMTALA requires.

7 I welcome the Court's questions.

8 JUSTICE THOMAS: General, are you
9 aware of any other Spending Clause legislation
10 that preempts criminal law?

11 GENERAL PRELOGAR: With respect to
12 criminal law in particular, Justice Thomas, I'm
13 not immediately thinking of relevant cases. We
14 have a whole string cite of cases in our brief
15 at page 46 that reflect times where the Court
16 has recognized the preemptive force of Spending
17 Clause legislation, including in situations
18 where the funding restrictions apply to private
19 parties, so that could include the Coventry
20 Health case, for example. Lead-Deadwood is
21 another example of this. But I'm not
22 immediately recalling how that would apply in
23 criminal law.

24 Of course, this Court hasn't drawn
25 those kinds of distinctions in recognizing the

1 force of the Supremacy Clause.

2 JUSTICE THOMAS: Now the -- normally,
3 when we have a -- a preemption case, it's a
4 regulated party who is involved in the suit, and
5 they use it as an affirmative defense, for
6 example, in Wyeth or something.

7 On the -- in this case, you are
8 bringing an action against the state, and the
9 state's not regulated. Are there other examples
10 of these types of suits?

11 GENERAL PRELOGAR: Sure. I mean,
12 there are numerous examples where the United
13 States has sought to protect its sovereign
14 interests in situations where a state has done
15 what Idaho has done here and interposed a law
16 that conflicts. So I'd point to Arizona versus
17 United States as an example of that. United
18 States versus Washington. There are a number of
19 cases where this Court has recognized that the
20 federal government can protect its interests in
21 this kind of preemption action.

22 And, as I mentioned before, the Court
23 has a long line of cases recognizing that that
24 preemption principle applies in the context of
25 federal funding restrictions that apply to

1 private parties too.

2 JUSTICE THOMAS: Even when the party
3 that you're bringing the action against is not a
4 regulated party?

5 GENERAL PRELOGAR: That's correct,
6 because what Idaho has done here is directly
7 interfered with the ability of the regulated
8 parties who have taken these funds, federal
9 funds with conditions attached, from being able
10 to comply with the federal law that governs
11 their behavior. And this was an essential part
12 of the bargain that the federal government
13 struck with hospitals in substantially investing
14 in their hospital systems.

15 And what the state has done is said
16 you, through our operation of state law, are no
17 longer permitted to comply with this fundamental
18 stabilization requirement in EMTALA in this
19 narrow category of cases.

20 JUSTICE THOMAS: Well, normally,
21 wouldn't it be the regulated party that would
22 actually be asserting the preemption that you're
23 talking about?

24 GENERAL PRELOGAR: Certainly, I can
25 imagine situations, for example, where a

1 regulated party would assert a preemption
2 defense and to say the state law itself is
3 preempted to the extent that it prevents that
4 party from being able to comply with federal
5 law. But I'm not aware of any principle or
6 precedent in this Court's case law to suggest
7 that that's the only way for the government to
8 protect its sovereign interests.

9 JUSTICE THOMAS: That is the normal
10 way, though?

11 GENERAL PRELOGAR: I think that that's
12 often the fact pattern of particular cases.

13 JUSTICE ALITO: I don't understand how
14 your argument about preemption here squares with
15 the theory of Spending Clause -- of Congress's
16 Spending Clause power. The theory is Congress
17 can tell a state or any other entity or person,
18 look, here's some money or other thing of value,
19 and if you want to accept it, fine, then you
20 have to accept certain conditions.

21 But how does the Congress's ability to
22 do that authorize it to impose duties on another
23 party that has not agreed to accept this money?

24 GENERAL PRELOGAR: There are no duties
25 being imposed on Idaho here. It's not required

1 to provide emergency stabilizing treatment
2 itself. The duties are -- are --

3 JUSTICE ALITO: Well, all right.

4 GENERAL PRELOGAR: -- applied to the
5 hospital.

6 JUSTICE ALITO: Not -- not duties.

7 How can you impose restrictions on what Idaho
8 can criminalize simply because hospitals in
9 Idaho have chosen to participate in Medicare? I
10 don't understand how this squares with the whole
11 theory of the Spending Clause.

12 GENERAL PRELOGAR: Well, I think that
13 it squares with this Court's long line of
14 precedents cited at --

15 JUSTICE ALITO: Well --

16 GENERAL PRELOGAR: -- page 46 of our
17 brief --

18 JUSTICE ALITO: Well, I -- I've --
19 I've looked at them.

20 GENERAL PRELOGAR: -- that the Court
21 has recognized that --

22 JUSTICE ALITO: I've looked at those
23 cases. I haven't found any square discussion of
24 this particular issue. But I -- I'm interested
25 in the theory. Can you just explain how it

1 works in theory?

2 GENERAL PRELOGAR: Sure. So Spending
3 Clause legislation is federal law. It's passed
4 by both houses of Congress. It's signed by the
5 president. It qualifies as law within the
6 meaning of the Supremacy Clause, and --

7 JUSTICE ALITO: Absolutely.
8 Absolutely.

9 GENERAL PRELOGAR: And -- and so I
10 think the Supremacy Clause dictates the relevant
11 principle here --

12 JUSTICE ALITO: No, but what the law
13 --

14 GENERAL PRELOGAR: -- that in a
15 situation where --

16 JUSTICE ALITO: I'll let you finish.
17 Yes, go ahead.

18 GENERAL PRELOGAR: In a situation
19 where Congress has enacted law, it has full
20 force and effect under the Supremacy Clause, and
21 what a state can't do is interpose its own law
22 as a direct obstacle to being able to fulfill
23 the federal funding conditions. And this
24 theory, Justice Alito --

25 JUSTICE ALITO: No, it's -- it's a --

1 GENERAL PRELOGAR: -- would mean no
2 conditions --

3 JUSTICE ALITO: -- it's a question --

4 GENERAL PRELOGAR: -- under Medicare
5 are enforceable.

6 JUSTICE ALITO: -- it's -- no.
7 They're absolutely enforceable against the
8 hospital that chooses to participate.

9 GENERAL PRELOGAR: Well, I guess the
10 -- the argument then would be that if a hospital
11 is instead bound by the state law and the state
12 law gets to control, it would mean that
13 hospitals couldn't participate in Medicare at
14 all.

15 And that's not the argument that the
16 State's making here. What it wants is for its
17 hospitals to be able to accept Medicare funding
18 but not have to face the restrictions that are
19 attached to those funds as an essential part of
20 the bargain. And there is no precedent to
21 support that outcome.

22 JUSTICE ALITO: Well, I -- I -- I just
23 don't think -- I don't understand how -- how the
24 theory works. But let me move on to something
25 else.

1 Let -- I'm going to try to restate
2 your general theory, and I want you to tell me
3 if this is right. I think your argument is, if
4 a woman goes to an emergency room and she has a
5 condition that requires an abortion in order to
6 eliminate "serious jeopardy" to her "health,"
7 the hospital must perform the abortion or
8 transfer the woman to another hospital where
9 that can be done.

10 Is that a fair statement of your
11 argument?

12 GENERAL PRELOGAR: So it includes not
13 just serious jeopardy to her health but,
14 obviously, also serious dysfunction of her
15 bodily --

16 JUSTICE ALITO: Right. Right.

17 GENERAL PRELOGAR: -- organs or a
18 serious impairment of a bodily function.

19 JUSTICE ALITO: Right.

20 GENERAL PRELOGAR: And the other
21 caveat I would make is that it would -- it would
22 require pregnancy termination only in a
23 circumstance where that's the only possible way
24 to stabilize her and prevent that cascade of
25 health consequences.

1 JUSTICE ALITO: Does this apply at any
2 point in pregnancy?

3 GENERAL PRELOGAR: So the pregnancy
4 complications that we have focused on generally
5 occur in early pregnancy, often before the point
6 of viability. There can be complications that
7 happen after viability, but there, the standard
8 of care is to deliver the baby if you need the
9 pregnancy to end because it's causing these
10 severe health consequences for the mom.

11 JUSTICE ALITO: Well, what if it --
12 what if it occurs at a point where delivering
13 the baby is not an option? You're out of the
14 third trimester, but it's really not an option
15 to deliver the baby.

16 GENERAL PRELOGAR: You said that
17 you're in the --

18 JUSTICE ALITO: Out of the first
19 trimester.

20 GENERAL PRELOGAR: -- third trimester?

21 JUSTICE ALITO: No. I'm sorry. Out
22 of the first trimester.

23 GENERAL PRELOGAR: So, if you're
24 contemplating a situation where delivery is not
25 an option, then I think, in that circumstance,

1 if the only way to prevent grave risk to the
2 woman's health or life is for the pregnancy to
3 end and termination is the only option, then,
4 yes, that's the required care that EMTALA has
5 through its stabilization mandate.

6 But, critically, in -- in many of
7 these cases --

8 JUSTICE ALITO: Okay. That -- that --

9 GENERAL PRELOGAR: -- the very same
10 pregnancy complication means the fetus can't
11 survive regardless.

12 JUSTICE ALITO: I -- I understand
13 that.

14 GENERAL PRELOGAR: There's not going
15 to be any way to sustain that pregnancy.

16 JUSTICE ALITO: Let me ask you
17 squarely the question that was discussed during
18 Mr. Turner's argument. Does the term "health"
19 in EMTALA mean just physical health, or does it
20 also include mental health?

21 GENERAL PRELOGAR: There can be grave
22 mental health emergencies, but EMTALA could
23 never require pregnancy termination as the
24 stabilizing care.

25 JUSTICE ALITO: Why?

1 GENERAL PRELOGAR: And here's why.
2 It's because that wouldn't do anything to
3 address the underlying brain chemistry issue
4 that's causing the -- the mental health
5 emergency in the first place. This is not about
6 mental health generally. This is about
7 treatment by ER doctors in an emergency room.
8 And when a woman comes in with some grave mental
9 health emergency, if she happens to be pregnant,
10 it would be incredibly unethical to terminate
11 her pregnancy. She might not be in a position
12 to give any informed consent. Instead, the way
13 you treat mental health emergency is to address
14 what's happening in the brain. If you're having
15 a psychotic episode, you administer
16 antipsychotics.

17 JUSTICE ALITO: Well, I -- I really
18 want a simple, clear-cut answer to this question
19 so that going forward everybody will know what
20 the federal government's position is. Does
21 "health" mean only physical health, or does it
22 also include mental health?

23 GENERAL PRELOGAR: With respect to
24 what qualifies as an emergency medical
25 condition, it can include grave mental health

1 emergencies, but let me be very clear about our
2 position. That could never lead to pregnancy
3 termination because that is not the accepted
4 standard of practice to treat any mental health
5 emergency.

6 JUSTICE ALITO: Does the term "serious
7 jeopardy" in -- in (e)(11)(i) mean an immediate
8 serious risk, or may a risk of serious
9 consequences at some future point suffice?

10 GENERAL PRELOGAR: The standard is
11 defined in terms of whether you need immediate
12 medical treatment. And so the relevant question
13 is, in the absence of immediate medical
14 treatment, are you going to have this serious
15 jeopardy to your health, dysfunction of your
16 organs, will your bodily systems start shutting
17 down, so it is pegged to the urgency of acute
18 care in an emergency room.

19 JUSTICE ALITO: So it has to be
20 immediate?

21 GENERAL PRELOGAR: The -- the relevant
22 standard under the statute is phrased in terms
23 of whether these consequences will occur without
24 immediate treatment, yes. So it's focused on
25 the interaction between having some kind of

1 urgent health crisis that takes you to an
2 emergency room in the first place and then how
3 proximate these -- these consequences are likely
4 to be.

5 JUSTICE ALITO: Well, there are two
6 different things there, whether the person is --
7 whether the woman is in immediate jeopardy or
8 whether the person -- the woman needs immediate
9 care in order to eliminate jeopardy at a later
10 point.

11 So I understand your answer to be that
12 the woman need not be in immediate jeopardy, but
13 if she doesn't get care right away, jeopardy at
14 some future point may suffice?

15 GENERAL PRELOGAR: So the statutory
16 standard itself is focused on immediate health
17 risks. It's looking at the possibility that if
18 the woman doesn't get treatment then and there,
19 what will happen, what will reasonably be
20 expected to occur is that her organs could start
21 shutting down or she might lose her fertility or
22 have other serious health consequences.

23 It is focused on this temporal link
24 between the immediate need for treatment, which
25 is I think reflective of the fact that Congress

1 was narrowly focused on this emergency acute
2 medical situation.

3 JUSTICE ALITO: Do the terms
4 "impairment to bodily functions" or "serious
5 dysfunction of any bodily organ or part" refer
6 only to permanent impairment or dysfunction?

7 GENERAL PRELOGAR: I think --

8 JUSTICE ALITO: Or do -- does it also
9 refer to temporary impairment or dysfunction?

10 GENERAL PRELOGAR: I think it can also
11 refer to temporary impairment, but I'm not sure
12 that it's easy to parse the two. For example, a
13 lot of times a pregnant woman in distress, she
14 might start suffering liver damage or kidney
15 malfunction, and you don't know ex ante whether
16 that's going to be permanent or not. The
17 instruction that Congress gave in EMTALA is you
18 need to stabilize to guard against those very
19 serious health risks.

20 JUSTICE GORSUCH: General, I'd -- I'd
21 like to -- if you -- yeah, just understand kind
22 of the scope of your argument here on the
23 Supremacy Clause and how it operates in your
24 mind, putting aside the -- this case.

25 Could the federal government condition

1 the receipt of funds on hospitals that they
2 comply with medical ethics rules provided for by
3 the federal government, a medical malpractice
4 regime, and a medical licensing regime such that
5 effectively all state medical malpractice laws,
6 all state medical licensing laws would be
7 preempted?

8 GENERAL PRELOGAR: And you're
9 imagining that this is regulatory action or that
10 Congress has passed a statute creating kind of a
11 federal malpractice regime?

12 JUSTICE GORSUCH: You call it.

13 GENERAL PRELOGAR: I mean, I think I
14 have a broad view of Congress's authority to
15 enact statutes, and so what I'd want to assess
16 in that situation is, you know, whether Congress
17 is acting pursuant to one of its enumerated
18 powers.

19 JUSTICE GORSUCH: Spending Clause.
20 This is all Spending Clause.

21 GENERAL PRELOGAR: Yeah. So -- so I
22 think that very likely Congress could make those
23 kinds of judgments and attach conditions to the
24 receipt of federal funds. And, you know, in
25 Medicare, there are substantial conditions.

1 JUSTICE GORSUCH: Even if it covers
2 all hospitals in the state and effectively
3 transforms the regulation of medicine into a
4 federal function --

5 GENERAL PRELOGAR: You know, there
6 might be a point --

7 JUSTICE GORSUCH: -- historically?

8 GENERAL PRELOGAR: -- at which this
9 Court thinks that it's really encroaching on the
10 state's prerogatives in ways that are
11 inconsistent with our constitutional structure,
12 but I don't think --

13 JUSTICE GORSUCH: You don't --

14 GENERAL PRELOGAR: -- we're anywhere
15 close to that --

16 JUSTICE GORSUCH: -- you don't see --

17 GENERAL PRELOGAR: -- in this case.

18 JUSTICE GORSUCH: But do you see any
19 bounds just in principle?

20 GENERAL PRELOGAR: I think the bounds,
21 you know, would have to come from this Court's
22 case law concerning federalism principles. The
23 Court has said in cases like *Gonzales versus*
24 *Oregon* that, of course, the federal government
25 has authority to comprehensively regulate on

1 health and safety, including with respect to
2 medical care. And so I don't think that there's
3 any principle of exclusive governance of this
4 area by the state.

5 But, obviously, I'm sure you could
6 construct hypotheticals that really --

7 JUSTICE GORSUCH: All right. Okay.

8 GENERAL PRELOGAR: -- seem to be the
9 federal government entirely taking over a state
10 function and maybe that would be subject to a
11 different principle.

12 JUSTICE GORSUCH: Yeah. And EMTALA
13 and -- and Medicare allow the federal government
14 to enforce the EMTALA dictate through civil
15 monetary penalties?

16 GENERAL PRELOGAR: That's correct,
17 yes.

18 JUSTICE GORSUCH: And also, you can
19 terminate the Medicare agreements if a hospital
20 violates EMTALA in your view?

21 GENERAL PRELOGAR: Yes. Generally,
22 the hospital is given the opportunity to come
23 into compliance and to develop a plan to ensure
24 that there won't be future EMTALA violations.
25 It would obviously be an extreme sanction to --

1 to terminate Medicare funding, but that is a
2 possibility.

3 JUSTICE GORSUCH: And there's also a
4 private right of action for EMTALA violations
5 that it have the possibility of equitable relief
6 as well?

7 GENERAL PRELOGAR: Yes. Certainly,
8 monetary relief and -- and possibly equitable
9 relief as well.

10 JUSTICE GORSUCH: In -- in this case,
11 you -- you -- you brought an equitable cause of
12 action. You didn't cite any statute to enforce
13 EMTALA. And one of the rules in equity
14 traditionally at least is that you don't get an
15 equitable relief if there's an adequate remedy
16 at law.

17 And as we just discussed, there's a
18 pretty reticulated statute here. Seminole Tribe
19 says, when you have a reticulated statute and
20 lots of remedial options, you don't get
21 equitable relief. Thoughts?

22 GENERAL PRELOGAR: So let me say at
23 the outset that the United States has long been
24 recognized to have an action in equity, an
25 inherent action in equity to appeal to the

1 courts of this -- of this nation to protect its
2 sovereign interests. And that's been reflected
3 in things like --

4 JUSTICE GORSUCH: Its sovereign -- its
5 proprietary interests? You mentioned Washington
6 and you mentioned --

7 GENERAL PRELOGAR: Arizona versus --

8 JUSTICE GORSUCH: -- Arizona.

9 GENERAL PRELOGAR: -- United States --

10 JUSTICE GORSUCH: Arizona was an --

11 GENERAL PRELOGAR: -- is another
12 example of that. I'd also --

13 JUSTICE GORSUCH: Arizona -- Arizona
14 was -- just sorry to interrupt, but Arizona was
15 an immigration case and --

16 GENERAL PRELOGAR: Right.

17 JUSTICE GORSUCH: -- the border, and
18 Washington was an attempt by a state to impose
19 its worker compensation laws on the federal
20 government in a way different from others. I --
21 I take those points. And equity is all about
22 proprietary interests and things like that. Do
23 we have that here?

24 GENERAL PRELOGAR: The -- well, I
25 think that the Court -- it's not -- I want to

1 make sure to make clear that there are a long
2 line of cases that stand for this principle,
3 including cases that have addressed it directly,
4 like In re Debs --

5 JUSTICE GORSUCH: Oh, Debs.

6 GENERAL PRELOGAR: -- Wyandot, so --

7 JUSTICE GORSUCH: Do you really want
8 to rely on Debs, General? I mean, that wasn't
9 exactly our brightest moment.

10 GENERAL PRELOGAR: I do think, though,
11 that it reflects the history and tradition of
12 this nation in recognizing that it's entirely
13 appropriate for the United States to seek to
14 protect its interests in this manner.

15 And let me say, Justice Gorsuch --

16 JUSTICE GORSUCH: What do you --

17 GENERAL PRELOGAR: -- this is a really
18 important issue to the United States. It wasn't
19 pressed below. It wasn't passed upon.

20 JUSTICE GORSUCH: I'm just trying --

21 GENERAL PRELOGAR: We haven't briefed
22 it at all.

23 JUSTICE GORSUCH: I'm trying to --

24 GENERAL PRELOGAR: It's not
25 jurisdictional.

1 JUSTICE GORSUCH: I'm just trying to
2 understand where it comes from. What is the
3 proprietary interest here?

4 GENERAL PRELOGAR: It comes from --

5 JUSTICE GORSUCH: It seems to me
6 it's -- it's your money and how it's being
7 spent, and Congress has given you lots of tools.

8 GENERAL PRELOGAR: I think it also
9 comes from the recognition under obstacle
10 preemption principles that there are important
11 functions to be served by having the Medicare
12 program in place.

13 And Idaho has directly interfered with
14 the ability of hospitals to accept these federal
15 funds when they stand willing and able to comply
16 with EMTALA's mandates and fulfill Congress's
17 desire here to make sure that no matter where
18 you are in this country, if you have an urgent
19 medical need and you go to an ER, you can be
20 stabilized.

21 JUSTICE GORSUCH: Thank you.

22 JUSTICE JACKSON: General, is there --

23 CHIEF JUSTICE ROBERTS: Counsel, your
24 friend on the other side said that your position
25 would require religiously affiliated hospitals

1 with emergency rooms to perform abortions. Was
2 he right?

3 GENERAL PRELOGAR: No. My friend was
4 wrong. There are federal conscience protections
5 that apply at the entity level to hospitals as
6 well. The key provisions are in the Weldon
7 amendment and also Coats-Snowe, although that
8 depends on the residency program of a particular
9 hospital.

10 Now HHS said in a 2008 rulemaking on
11 conscience protections that it had never come
12 across a hospital that had a blanket objection
13 to providing life-preserving and
14 health-preserving pregnancy termination care,
15 but if a hospital had that kind of objection,
16 and HHS recently informed me they still have not
17 come across that hospital, that would be honored
18 vis-à-vis HHS's enforcement ability.

19 CHIEF JUSTICE ROBERTS: You said that
20 applies at the entity level. Can individual
21 doctors in the emergency room -- do they have a
22 conscience exemption?

23 GENERAL PRELOGAR: Oh, yes. Yes.
24 They're protected under the church amendments
25 principally. And our position is that EMTALA

1 does not override either set of conscience
2 protections. So, if an individual doctor has a
3 conscience objection to providing pregnancy
4 termination, EMTALA itself imposes obligations
5 at the entity level, and the hospital should
6 have plans in place to honor the individual
7 doctor's conscience objection while ensuring
8 appropriate staffing for emergency care.

9 CHIEF JUSTICE ROBERTS: Well, does
10 that -- does that mean that there must be
11 somebody in the emergency room that can provide
12 an abortion? What if -- what if there are two
13 doctors, three doctors, and they all have a
14 conscience exemption?

15 GENERAL PRELOGAR: No. In that
16 circumstance, EMTALA could not override those
17 individual doctors' conscience protections, but
18 my understanding is that as a matter of best
19 practice, because hospitals want to be able to
20 provide emergency care, they do things like ask
21 doctors to articulate their objections in
22 advance so that that can be taken into account
23 in making staffing decisions and who's on call.
24 Hospitals have a lot of plans in place --

25 CHIEF JUSTICE ROBERTS: Are -- are you

1 saying --

2 GENERAL PRELOGAR: -- for these kinds
3 of contingencies.

4 CHIEF JUSTICE ROBERTS: Yeah. Are --
5 are you saying that there must be somebody
6 available and on call in -- in a hospital of
7 that sort?

8 GENERAL PRELOGAR: The conditions of
9 participation for Medicare require hospitals to
10 be appropriately staffed to provide emergency
11 treatment. Now, in a situation where a hospital
12 doesn't -- hasn't done that and it doesn't have
13 anyone on hand who can provide care, you know,
14 maybe all of the doctors called in sick that day
15 and there's just literally no one in the
16 emergency room, or in this case, if everyone had
17 a conscience objection, then the hospital would
18 not be able to provide the care. But there are
19 conditions of participation that are meant to
20 ensure that there is good governance of
21 hospitals and organization to account --

22 CHIEF JUSTICE ROBERTS: When you say
23 --

24 GENERAL PRELOGAR: -- for these
25 situations.

1 CHIEF JUSTICE ROBERTS: -- and the
2 consequence of them not being able to provide
3 the care would be what?

4 GENERAL PRELOGAR: In that
5 circumstance, I think they would likely be out
6 of compliance with the conditions of
7 participation that require them to be
8 appropriately staffed. But, if the question is
9 could you force an individual doctor to step in
10 then over a conscience objection, the answer is
11 no, and I want to be really clear about that.

12 CHIEF JUSTICE ROBERTS: I know, but
13 the question --

14 GENERAL PRELOGAR: We don't understand
15 EMTALA to displace it.

16 CHIEF JUSTICE ROBERTS: Excuse me.
17 The question is whether or not they must have
18 available someone who can comply the procedures
19 required by EMTALA. And what would be the
20 consequence if they didn't? Would it be
21 eventual termination of their participation in
22 Medicare?

23 GENERAL PRELOGAR: That's right. So,
24 if a hospital was continually disobeying the
25 requirement to have in place sufficient

1 personnel to run their emergency room, then I
2 imagine that HHS would, through enforcement
3 action, work with that hospital to try to bring
4 it into compliance. And if the hospital
5 ultimately is just leaving itself in a position
6 where it can never provide care, then it would
7 terminate the Medicare funding agreement.

8 JUSTICE GORSUCH: I thought --

9 JUSTICE BARRETT: General --

10 JUSTICE GORSUCH: -- you just said a
11 minute ago -- I'm sorry.

12 JUSTICE BARRETT: Oh, no, go ahead.

13 JUSTICE GORSUCH: I thought you -- I
14 just want to clarify this colloquy. I thought
15 you said a minute ago, though, if the hospital
16 had a conscience objection and therefore didn't
17 provide certain care, that that wouldn't render
18 it out of compliance. Which is it?

19 GENERAL PRELOGAR: That's correct.

20 JUSTICE GORSUCH: Okay. All right.

21 GENERAL PRELOGAR: So the hospital
22 could assert a conscience objection --

23 JUSTICE GORSUCH: That's all.

24 GENERAL PRELOGAR: -- and EMTALA would
25 not override that.

1 JUSTICE BARRETT: My question -- I
2 have a question about the Hyde amendment. So I
3 gather from the briefing that there might be
4 some situations in which EMTALA would require an
5 abortion, but the Hyde amendment wouldn't permit
6 federal funds to be used to pay for it. And you
7 said in your brief that EMTALA requires in other
8 circumstances as well stabilizing treatment to
9 be given that federal funds don't cover.

10 Can you give an example of that? And
11 am I right about the Hyde amendment? And then
12 can you give an example of that?

13 GENERAL PRELOGAR: Yes. So you are
14 right about both things. It is common under
15 EMTALA that hospitals are going to have to
16 provide care where there's not federal funding
17 available. And I'll give you an example of a
18 Medicare patient who goes in and his emergency
19 medical condition means he needs a particular
20 drug that's not covered by Medicare benefits.
21 Still, the hospital has to provide him with
22 stabilizing treatment and give him that
23 medication, even though the federal funding
24 isn't going to pay for it.

25 And that also applies to people who

1 are uninsured, who aren't covered by Medicare in
2 the first instance. The -- the whole point of
3 EMTALA was it doesn't matter your circumstances,
4 it doesn't matter whether you can pay or not, it
5 doesn't matter the particulars of your
6 situation, this is a guarantee. You can get
7 stabilizing treatment.

8 I want to say, though, that I don't
9 think there's any inconsistency between the
10 lines Congress drew in EMTALA and Hyde. And
11 Congress itself has recognized that these
12 statutes address discrete issues. I'm thinking
13 here of the provision in the Affordable Care Act
14 that was exclusively about abortion, and there,
15 Congress said nothing in the ACA displaces Hyde
16 and the other federal funding restrictions on
17 abortion, but also, nothing in the ACA displaces
18 EMTALA's requirement to stabilize.

19 And that shows two things. It shows
20 first that Congress recognized that stabilizing
21 care can sometimes be pregnancy termination.
22 And I think it also showed Congress's
23 recognition that these statutes addressed their
24 own distinct spheres.

25 And one final point on Hyde, Justice

1 Barrett. My friend isn't drawing a line based
2 on Hyde either because his point is, even if a
3 woman is on the brink of death and she goes to
4 an emergency room and there are federal funds
5 available under Hyde to treat her, still,
6 hospitals have no obligation under EMTALA to
7 provide that care.

8 JUSTICE BARRETT: So what about the
9 colloquy I was having with your friend about
10 what stabilizing treatment entails? Let's
11 imagine a situation in which a woman is, I don't
12 know, 10 weeks, and is told that if you carry
13 this pregnancy to term, it could have, you know,
14 consequences for your health, but you just would
15 need to abort before, like, say, 15 weeks,
16 something like that. So there's not an
17 immediacy, like -- so she's stable when she
18 leaves the hospital, but in Idaho, there's no
19 place else that she can go at least until she's
20 15 weeks.

21 What is the federal government's
22 position then?

23 GENERAL PRELOGAR: I think, if I'm
24 understanding the hypothetical correctly, that
25 she likely wouldn't have an emergency medical

1 condition in the first place because the
2 definition of having an emergency medical
3 condition is that, without immediate treatment,
4 you are reasonably -- you will reasonably be
5 expected to have serious dysfunction of your
6 organs or serious impairment of your bodily
7 functions.

8 And so, in that situation where a
9 woman is somewhat high risk, you know, maybe she
10 -- she has certain complications where doctors
11 can say there's some danger with continuing this
12 pregnancy, I don't think that that creates the
13 kind of emergency medical condition that EMTALA
14 is aimed at.

15 JUSTICE BARRETT: Okay. Last
16 question, and this is about the Spending Clause
17 issue.

18 So it does seem odd -- and I think
19 kind of what some of the questions are getting
20 at -- it does seem odd that through a side
21 agreement between a private entity and the
22 federal government, the private entity can get
23 out of state law, right?

24 So, in another administration, would
25 it be possible then in reliance on the spending

1 power for Congress to say, you know, any
2 hospital that takes these funds cannot perform
3 abortions or any hospital -- despite state law
4 requiring -- a state constitutional amendment
5 requiring abortion to be available, is that
6 possible or, you know, with gender reassignment
7 surgery? I mean, you can imagine it kind of
8 going back and forth through Spending Clause
9 litigation in ways that would be unusual.

10 GENERAL PRELOGAR: Yes, I think
11 Congress has broad power under the Spending
12 Clause to attach conditions. Now it doesn't
13 mean that it's wholly unlimited. Obviously,
14 Congress would be having to act pursuant to an
15 enumerated power, it would have to comply with
16 other constitutional limits, and so the law
17 would have to be valid. The Spending Clause
18 itself has built-in limits, things like
19 relatedness and clear notice.

20 JUSTICE BARRETT: So it would have to
21 be acting pursuant to an enumerated power in
22 forbidding gender reassignment surgery or
23 abortion or those sorts of things?

24 GENERAL PRELOGAR: Oh, no. I just
25 meant that it would have to be valid spending.

1 JUSTICE BARRETT: The Spending Clause?

2 GENERAL PRELOGAR: The Spending Clause

3 --

4 JUSTICE BARRETT: The Spending Clause.

5 GENERAL PRELOGAR: -- itself would be
6 enough.

7 JUSTICE BARRETT: Okay. Okay.

8 GENERAL PRELOGAR: Yes. So we think

9 --

10 JUSTICE GORSUCH: Yeah. So --

11 GENERAL PRELOGAR: -- the Spending
12 Clause itself would be enough.

13 JUSTICE GORSUCH: -- so just to follow
14 up on that and going back to where I started
15 with could -- could the federal government
16 essentially regulate the practice of medicine of
17 the states through the Spending Clause, the
18 answer, I think, is yes, Congress could prohibit
19 gender reassignment surgeries across the nation,
20 it could ban abortion across the nation, through
21 the use of its Spending Clause authority, right?

22 GENERAL PRELOGAR: Congress does have
23 broad authority under the Spending Clause. And,
24 yes, if it satisfies the conditions that the
25 Spending Clause itself -- itself requires,

1 then I think that that would be valid
2 legislation.

3 JUSTICE GORSUCH: How --

4 GENERAL PRELOGAR: And the Court has
5 in many contexts recognized --

6 JUSTICE GORSUCH: How do we --

7 GENERAL PRELOGAR: -- the Spending
8 Clause legislation preempts. So to Justice --

9 JUSTICE GORSUCH: So the -- the answer
10 is yes? Okay.

11 So how do we reconcile that with the
12 statement in 1395 that nothing in this
13 subchapter allows a federal officer to exercise
14 any control over the practice of medicine?

15 GENERAL PRELOGAR: So, at the outset,
16 I think, if Congress itself is doing it, then
17 that provision is inapplicable by its own terms.
18 That's looking at the --

19 JUSTICE GORSUCH: You don't think it
20 informs our view and understanding of the
21 statute in any way?

22 GENERAL PRELOGAR: Well, I think, in
23 the event of some kind of direct conflict, you
24 know, looking at EMTALA in particular, it's the
25 later in time enacted statute, and it's clearly

1 more specific, so it would control.

2 But this Court itself has rejected the
3 idea that there would be that kind of conflict.
4 And I'm thinking of the CMS vaccine case, where
5 the litigants relied on this exact same
6 provision of the Medicare Act, Section 1395, and
7 this Court said no, that can't bear the weight
8 that those litigants could place on it or it
9 would call into question all of the conditions
10 of participation in Medicare.

11 JUSTICE GORSUCH: Do you agree that
12 our clear statement rule with respect to
13 Spending Clause legislation, our clear statement
14 rule with respect to federalism are in play
15 here?

16 GENERAL PRELOGAR: I think that here,
17 Congress has spoken clearly with respect to what
18 providers --

19 JUSTICE GORSUCH: Oh, I -- I --

20 GENERAL PRELOGAR: -- are supposed to
21 do.

22 JUSTICE GORSUCH: That's not the
23 question. Do you think those presumptions
24 apply? Forget about whether you can satisfy
25 them.

1 GENERAL PRELOGAR: The requirement of
2 clear notice under Spending Clause legislation,
3 yes, I think that that does apply, and providers
4 have always understood their obligations under
5 EMTALA.

6 JUSTICE GORSUCH: Okay.

7 JUSTICE JACKSON: General, let me ask
8 you to respond to a couple of things
9 Petitioners' counsel said and just give you the
10 opportunity to respond.

11 He suggested or said that you haven't
12 identified a circumstance in which something
13 that EMTALA requires Idaho wouldn't allow. And
14 I -- I didn't get a chance to ask him, but I
15 took -- I took him to sort of mean that the way
16 that Idaho's statute operates, it basically
17 allows for a doctor to say, well, in my view,
18 you know, this health-threatening circumstance
19 could eventually lead to death, and so I'm going
20 to do it. So, to the extent that doctors are
21 still able to do that, I guess, he's saying
22 there's no preemption.

23 But is it true that there really isn't
24 in operation a difference between the two -- the
25 -- the EMTALA and what Idaho has required here?

1 GENERAL PRELOGAR: No. That is
2 gravely mistaken on three levels. It's
3 inconsistent with the actual text of the Idaho
4 law. It's inconsistent with medical reality.
5 And it's inconsistent with what's happening on
6 the ground.

7 And this is a really important point,
8 so let me try to unpack this. On the text
9 itself, Idaho's law only allows termination if
10 it's necessary to prevent death. And that is
11 textually very narrow compared to what EMTALA
12 requires with the category of harm to begin
13 with. In Idaho, doctors have to shut their eyes
14 to everything except death, whereas, under
15 EMTALA, you're supposed to be thinking about
16 things like, is she about to lose her fertility?
17 Is her uterus going to become incredibly scarred
18 because of the bleeding? Is she about to
19 undergo the possibility of kidney failure? So I
20 think that that is one critical distinction.

21 The other critical textual distinction
22 is the idea of necessity. Under Idaho law, you
23 have to conclude that death will necessarily
24 result, which is also materially different, and
25 the Idaho Supreme Court specifically recognized

1 it.

2 Second, with respect to the actual
3 medical reality here, there are numerous
4 conditions that we are worried about where a
5 doctor's immediate concern is not death. That's
6 a far more remote possibility. They're thinking
7 about the health circumstances that EMTALA
8 guards against.

9 And let me give you two examples. The
10 first is PPRM, premature rupture of the
11 membranes. We have declarations at 594 that
12 explain this in detail and also at JA 615 to
13 617.

14 What the doctors explained there --
15 this is Dr. Fleisher and Dr. Cooper -- is a
16 woman comes in with PPRM. Her sac is ruptured.
17 There's no chance the fetus is going to be able
18 to survive, but at that point, she doesn't have
19 active signs of infection, and so, until she
20 deteriorates, you can't think she's close to
21 death. What you're worried about is she will
22 become infected. She might develop sepsis. She
23 might have these dramatic consequences for her
24 future, but it's not about death. So I think
25 that is one example where you can't do it.

1 And then, finally, just the actual
2 practice on the ground, women in Idaho today are
3 not getting treatment. They are getting
4 airlifted out of the state to Salt Lake City and
5 to neighboring states where there are health
6 exceptions in their laws because the doctors are
7 facing mandatory minimum two years in prison,
8 loss of their license, criminal prosecution.

9 The doctors can't provide the care
10 because until they can conclude that a
11 prosecutor looking over their shoulder won't
12 second-guess that maybe it wasn't really
13 necessary to prevent death.

14 CHIEF JUSTICE ROBERTS: Thank you,
15 counsel.

16 Justice Thomas?

17 Justice Alito?

18 JUSTICE ALITO: We've now heard --
19 let's see -- an hour and a half of argument on
20 this case, and one potentially very important
21 phrase in EMTALA has hardly been mentioned.
22 Maybe it hasn't even been mentioned at all. And
23 that is EMTALA's reference to the woman's
24 "unborn child."

25 Isn't that an odd phrase to put in a

1 statute that imposes a mandate to perform
2 abortions? Have you ever seen an abortion
3 statute that uses the phrase "unborn child"?

4 GENERAL PRELOGAR: It's not an odd
5 phrase when you look at what Congress was doing
6 in 1989. There were well-publicized cases where
7 women were experiencing conditions, their own
8 health and life were not in danger, but the
9 fetus was in grave distress and hospitals
10 weren't treating them. So what Congress did --

11 JUSTICE ALITO: Well, have you seen --

12 GENERAL PRELOGAR: -- is that it --

13 JUSTICE ALITO: -- have you seen
14 abortion statutes that use the phrase "unborn
15 child"? Doesn't that tell us something?

16 GENERAL PRELOGAR: It tells us that
17 Congress wanted to expand the protection for
18 pregnant women so that they could get the same
19 duties to screen and stabilize when they have a
20 condition that's threatening the health and
21 well-being of the unborn child.

22 But what it doesn't suggest is that
23 Congress simultaneously displaced the
24 independent preexisting obligation to treat a
25 woman who herself is facing grave life and

1 health consequences.

2 JUSTICE ALITO: Well, let's walk
3 through the provisions of the statute that are
4 relevant to this issue regarding the status and
5 the potential interests of an unborn child.

6 Under (b)(1), if a woman goes to a
7 hospital with an "emergency medical condition"
8 -- that's the phrase -- the hospital must either
9 stabilize the condition or, under some
10 circumstances, transfer the -- the woman to
11 another facility.

12 So we have this phrase, "emergency
13 medical condition," in that provision. And
14 then, under (e)(1), the term "emergency medical
15 condition" is defined to include a condition
16 that places the health of the woman's unborn
17 child in serious jeopardy.

18 So, in that situation, the hospital
19 must stabilize the threat to the unborn child.
20 And it seems that the plain meaning is that the
21 hospital must try to eliminate any immediate
22 threat to the child, but performing an abortion
23 is antithetical to that duty.

24 GENERAL PRELOGAR: But, in a
25 circumstance --

1 JUSTICE ALITO: Now -- and you -- you
2 go -- you go so far as to say that the statute
3 is clear in your favor. I -- I don't know how
4 you can say that in light of the -- of those
5 provisions that I just read to you.

6 GENERAL PRELOGAR: The statute did
7 nothing to displace the woman herself as an
8 individual with an emergency medical condition
9 when her life is in danger, when her health is
10 in danger. That stabilization obligation
11 equally runs to her and makes clear that the
12 hospital has to give her necessary stabilizing
13 treatment.

14 And in many of the cases you're
15 thinking about, there is no possible way to --
16 to stabilize the unborn child because the fetus
17 is sufficiently before viability that it's
18 inevitable that the pregnancy is going to be
19 lost, but Idaho would deny women treatment in
20 that circumstance --

21 JUSTICE ALITO: Doesn't --

22 GENERAL PRELOGAR: -- even though it's
23 senseless.

24 JUSTICE ALITO: Doesn't what I've read
25 to you show that the statute imposes on the

1 hospital a duty to the woman certainly and also
2 a duty to the child? And it doesn't tell the
3 hospital how it is to adjudicate conflicts
4 between those interests and it leaves that to
5 state law.

6 Now maybe a lot -- most of your
7 argument today has been dedicated to the
8 proposition that the Idaho law is a bad law, and
9 that may well be the case. But what you're
10 asking us to do is to construe this statute that
11 was enacted back during the Reagan
12 administration and signed by President Reagan to
13 mean that there's an obligation under certain
14 circumstances to perform an abortion even if
15 doing that is a violation of state law.

16 GENERAL PRELOGAR: If Congress had
17 wanted to displace protections for pregnant
18 women who are in danger of losing their own
19 lives or their health, then it could have
20 redefined the statute so that the fetus itself
21 is an individual with an emergency medical
22 condition. But that's not how Congress
23 structured this. Instead, it put the protection
24 in to expand protection for the pregnant woman.
25 The duties still run to her.

1 And in a situation where her own life
2 and health is gravely endangered, then, in that
3 situation, EMTALA is clear. It says the
4 hospital has to offer her stabilizing treatment.

5 JUSTICE ALITO: The -- the only --

6 GENERAL PRELOGAR: And she doesn't
7 have to accept it. These are tragic
8 circumstances. And many women want to do
9 whatever they can to save that pregnancy. But
10 the statute protects her and gives her that
11 choice.

12 JUSTICE ALITO: The only way you try
13 to get out of the statutory interpretation that
14 I just posited is by focusing on the term
15 "individual." And you say, a-ha, in the
16 Dictionary Act, "individual" is defined to
17 exclude an unborn child or a fetus. That's the
18 only way you can try to get out of what I just
19 outlined.

20 And isn't it true that under the
21 dictionary -- that Dictionary Act definitions
22 apply only if they are not inconsistent with the
23 statutory text? And when you have a text that,
24 certainly, you wouldn't dispute the fact that
25 the hospital has a duty to the unborn child

1 where the woman wants to -- wants to have the
2 pregnancy go to term, it indisputably protects
3 the interests of the unborn child. So it's
4 inconsistent with the definition in the -- in
5 the Dictionary Act.

6 GENERAL PRELOGAR: No, not at all.
7 The duty runs to the individual with the
8 emergency medical condition. The statute makes
9 clear that's the pregnant woman. And, of
10 course, Congress wanted to be able to protect
11 her in situations where she's suffering some
12 kind of emergency and her own health isn't at
13 risk, but the fetus might die.

14 That includes common things like a
15 prolapse of the umbilical cord into the cervix,
16 where the fetus is in grave distress, but the
17 woman is not at all affected. Hospitals
18 otherwise wouldn't have an obligation to treat
19 her, and Congress wanted to fix that.

20 But to suggest that in doing so
21 Congress suggested that the woman herself isn't
22 an individual, that she doesn't deserve
23 stabilization, I think that that is an erroneous
24 reading of this statute.

25 JUSTICE ALITO: Nobody's suggesting

1 that the woman is not an individual and she
2 doesn't -- she doesn't deserve stabilization.

3 GENERAL PRELOGAR: Well, the --

4 JUSTICE ALITO: Nobody's suggesting
5 that.

6 GENERAL PRELOGAR: -- I think the
7 premise of the question would be that the State
8 of Idaho --

9 JUSTICE ALITO: It wasn't the premise.
10 It wasn't --

11 GENERAL PRELOGAR: -- can declare that
12 she cannot get the stabilizing treatment even if
13 she's about to die. That is their theory of
14 this case and this statute, and it's wrong.

15 CHIEF JUSTICE ROBERTS: Justice
16 Sotomayor?

17 JUSTICE SOTOMAYOR: General, this --
18 this lack of conflict which your opposing
19 colleague says doesn't exist, you mentioned a
20 situation where it does. Why don't you
21 succinctly state what you -- well, they admit
22 there's daylight. Tell us exactly how you
23 define where the daylight exists.

24 GENERAL PRELOGAR: The daylight, as I
25 see it, exists on two dimensions. They think

1 that doctors can only provide stabilizing care
2 when the woman is facing death. And we think,
3 no, you can take into account things like kidney
4 failure, the risk of a seizure, and life-long
5 neurological impacts based on that.

6 JUSTICE SOTOMAYOR: Well, they -- they
7 said the recent decision of the Oregon court
8 says you don't need death to be imminent or
9 immediate, I think, is the word they used if I'm
10 not wrong.

11 GENERAL PRELOGAR: So what the Idaho
12 Supreme Court said in that decision is that
13 there's no particular level of imminency and no
14 certain percent chance requirement. But what
15 the court couldn't do is turn away from the
16 language requiring the type of harm to
17 exclusively be death.

18 And also, the inherent concept of
19 necessity requiring some degree of imminence,
20 it's true that it's a subjective standard under
21 Idaho law, and the court made that clear, but
22 what the Idaho Supreme Court also said is
23 prosecutors are free to come in and have other
24 medical experts second-guess doctors' decisions
25 by saying maybe you didn't subjectively think

1 she really needed it as necessary to prevent
2 death because, look, her -- her sac had
3 ruptured, but she wasn't yet infected.

4 And that's exactly the kind of
5 situation that leads to women being driven out
6 of state, dumped on neighboring states by Idaho,
7 and criminalizing the care, the essential care
8 that they need.

9 JUSTICE SOTOMAYOR: Thank you.

10 CHIEF JUSTICE ROBERTS: Justice Kagan?

11 JUSTICE KAGAN: Yeah, if you could
12 just talk a little bit about that because, as I
13 understood it, for example, I read recently that
14 the hospital that has the greatest emergency
15 room services in Idaho has just in the few
16 months that this has been in place had to
17 airlift six pregnant women to neighboring
18 states, whereas, in the prior year, they did one
19 the entire year.

20 So, if Mr. Turner is right about what
21 the state is trying to convey to hospitals about
22 when they'll be prosecuted, like, why is this
23 happening?

24 GENERAL PRELOGAR: I think that the
25 reason this is happening is because those

1 doctors can look at the text of the statute
2 itself, they can look at the Idaho Supreme
3 Court's decision, which made clear, very clear,
4 that this was a departure from prior Idaho laws
5 that tracked EMTALA. And they can recognize
6 that their livelihood is on the line, their
7 medical license, their ability to practice
8 medicine, their freedom if they have to go to
9 jail and serve one of these minimum two-year
10 sentences of imprisonment, and they simply
11 cannot provide the care, even consistent with
12 their subjective medical judgment, because, as a
13 matter -- matter of medical reality, for many of
14 these conditions, it's not yet putting a woman
15 at the brink of death or necessary to prevent
16 her death, yet they know that the standard of
17 care is to provide her with termination because
18 she is just going to get worse and worse and
19 worse if they wait it out.

20 And the other important point about
21 this, and I think it goes back to this dual
22 stabilization idea, is that, tragically, in many
23 of these cases, the pregnancy is lost. There's
24 not going to be any way to save that fetus
25 because a woman who has PPRM at 17 weeks, there

1 is no medical way to sustain the pregnancy to
2 give the fetus a chance. So, in that situation,
3 what Idaho is doing is waiting for women to wait
4 and deteriorate and suffer the life-long health
5 consequences with no possible upside for the
6 fetus. It just stacks tragedy upon tragedy.

7 JUSTICE KAGAN: And it -- it -- it
8 can't be the appropriate -- you know, it's like
9 -- it's become -- transfer is the appropriate
10 standard of care in Idaho. But it can't be the
11 right standard of care to force somebody onto a
12 helicopter.

13 GENERAL PRELOGAR: And it's entirely
14 inconsistent with what Congress was trying to do
15 in the statute. You know, one of the primary
16 motivators here was to prevent patient dumping.
17 The idea was we don't want people to have to go
18 somewhere else to get their care. You go to the
19 first emergency room in your state, and they
20 have to treat you and stabilize you.

21 But this effectively allows states to
22 take any particular treatment they don't want
23 their hospitals to provide and dump those
24 patients out of state. And you can imagine what
25 would happen if every state started to take this

1 approach.

2 JUSTICE KAGAN: A question on the
3 Spending Clause questions that you've been
4 asked. I mean, what would -- if you accepted
5 some of these theories, what -- what would the
6 consequences of something like that be that we
7 would have to worry about?

8 GENERAL PRELOGAR: I think that it
9 would call into question any number of federal
10 spending statutes that provide funds to private
11 parties, and there are a bunch of them. You
12 know, there's the Medicare system itself, which
13 is, of course, a major federal spending program.
14 There are funds provided under Title VI, under
15 Title IX, a lot of federal statutes out there
16 that give funds to private parties and insist on
17 conditions of compliance with the federal
18 funding restrictions.

19 And if the Court were to suddenly say
20 that can't preempt contrary state law, then I
21 think that it would seriously interfere with the
22 ability of the federal government to get its
23 benefit of the bargain in those spending
24 programs.

25 JUSTICE KAGAN: And you mentioned

1 before that this question has never been a part
2 of this case?

3 GENERAL PRELOGAR: That's right. They
4 did not make these arguments in the lower court.
5 They briefly referred to the Spending Clause,
6 but I don't understand them to have pressed this
7 argument specifically. And so I think that --
8 the lower courts did not address it. I think
9 the district court said in a footnote, they
10 briefly refer to it in a footnote of their
11 brief, and it's essentially waived.

12 JUSTICE KAGAN: Thank you.

13 CHIEF JUSTICE ROBERTS: Justice --
14 Justice Kavanaugh?

15 JUSTICE KAVANAUGH: You've touched on
16 what's happening on the ground, and that's an
17 important consideration in answer to the
18 question of what's happening. But Idaho is
19 representing -- and I just want to get your
20 answer on this -- that, as I count it, nine
21 conditions that have been identified by the
22 government where EMTALA would require that an
23 abortion be available, an abortion is available
24 under Idaho law. And that's in the reply brief.

25 Now are there other conditions?

1 You've ruled out mental health. Are there other
2 conditions you would identify, or are you just
3 saying that that's not really happening on the
4 ground? I think that's part of your answer, but
5 I just want to get a fuller answer on that.

6 GENERAL PRELOGAR: It certainly isn't
7 happening on the ground. These are the
8 conditions that we're worried about. And I
9 think the problem with my friend's theory that
10 Idaho law would permit it is that you just can't
11 square it with the text of the statute.

12 You know, the -- the -- the --

13 JUSTICE KAVANAUGH: What -- what if
14 there were --

15 GENERAL PRELOGAR: -- State of Idaho
16 is --

17 JUSTICE KAVANAUGH: I'm sorry. Keep
18 going.

19 GENERAL PRELOGAR: Well, I just wanted
20 to say they're not the ultimate authority on
21 what the Idaho law means. That's the Idaho
22 Supreme Court, of course, and it has addressed
23 this issue in the Planned Parenthood case. And
24 I think it's really significant that, in Planned
25 Parenthood, the Idaho Supreme Court expressly

1 contrasted this statute with other statutes that
2 contain health-preserving measures and
3 recognized this was a -- a total departure from
4 that. The legislature wanted to focus
5 exclusively and more narrowly on a "necessary to
6 prevent death" exception.

7 So I think that -- that that
8 essentially means that the Supreme Court of
9 Idaho has already touched on this issue, and
10 it's no wonder then that doctors who are facing
11 these kinds of pregnancy complications, where,
12 in their medical judgment, it's not necessarily
13 to prevent death yet, but the woman is going to
14 suffer serious health consequences, their hands
15 are tied and they can't provide that care under
16 the Idaho law.

17 JUSTICE KAVANAUGH: If the -- what's
18 on page 8 and 9 of the reply brief were Idaho
19 law, would there be a problem still?

20 GENERAL PRELOGAR: So, if we had an
21 authoritative Idaho Supreme Court decision that
22 said Idaho law allows for termination in the
23 circumstances where EMTALA would require it,
24 yes, of course. Then the conflict goes away.
25 But I can't imagine --

1 JUSTICE KAVANAUGH: Well --

2 GENERAL PRELOGAR: -- the court would
3 say that because, of course, here --

4 JUSTICE KAVANAUGH: -- that's not
5 quite what 8 and 9 say, but I -- I take your
6 point on that.

7 A separate question, different
8 category. I think one of the themes on the
9 other side is that this law passed in 1986 was a
10 very important law addressing a very important
11 problem, namely, the problem where hospitals
12 were turning away poor and uninsured patients
13 who came in for emergency care, and the idea was
14 that can't happen. We can't allow hospitals in
15 this country to turn away poor and uninsured
16 people in emergencies.

17 But their theme is that the law was
18 not designed contextually to deal with specific
19 -- with abortion or other specific kinds of
20 care. And so they make a textual argument, but
21 I think they also make a broader contextual
22 argument about the whole idea of what was going
23 on in 1986. And I want to make sure -- I don't
24 think that's really come up too much. I want to
25 make sure you respond to that.

1 GENERAL PRELOGAR: I appreciate having
2 the chance to address that. So, at the outset,
3 I don't think they can square that theory with
4 the text of the statute, which says in no
5 uncertain terms here is the fundamental
6 guarantee. If you have an emergency medical
7 condition and you go to an ER in this country,
8 they have to stabilize you. They have to give
9 you such treatment as may be necessary within
10 reasonable medical probability to ensure that
11 you don't deteriorate.

12 And, yes, Congress did not provide a
13 reticulated list of all possible emergency
14 medical conditions and all possible treatments,
15 but it was very clear that Congress set a
16 baseline national standard of care to ensure
17 that no matter where you live in this country,
18 you can't be declined service and the -- the
19 urgent needs of your medical condition
20 addressed.

21 And, you know, it would be no
22 different if the state had come out and decided
23 to ban epinephrine. That's the singular way to
24 treat anaphylaxis, a severe allergic reaction.
25 That would violate the statute, and we would be

1 up here making the exactly same arguments
2 because Congress didn't want that. If you have
3 anaphylaxis and you go to an ER anywhere around
4 this country, they're going to give you
5 epinephrine, and Congress mandated that.

6 And I don't see any way to try to draw
7 lines around to exclude pregnancy complications
8 in the very narrow but tragic circumstances
9 where the only way to address the woman's
10 condition and prevent material deterioration is
11 for the pregnancy to end.

12 JUSTICE KAVANAUGH: Thank you.

13 CHIEF JUSTICE ROBERTS: Justice
14 Barrett?

15 JUSTICE BARRETT: So, General, I -- I
16 understand the primary difference between EMTALA
17 and the Idaho statute to be this health, that --
18 that Idaho focuses on the risk of life, but the
19 federal government says that EMTALA -- well,
20 EMTALA says that the health is -- am I right,
21 it's health and life?

22 GENERAL PRELOGAR: That's -- that's
23 the principal difference, but I think it's also
24 the difference between necessary to prevent
25 death versus the health concerns would be

1 reasonably expected to occur. So I think that
2 that is a standard that builds in a little more
3 space for doctors to take action.

4 JUSTICE BARRETT: Got it. Is the
5 federal government aware of any state other than
6 Idaho that has a law that does not take health
7 into account?

8 GENERAL PRELOGAR: There are six other
9 states that have severe abortion restrictions
10 without a health exception. So I think that
11 those are the primary category of states we're
12 concerned about here.

13 JUSTICE BARRETT: Thank you.

14 GENERAL PRELOGAR: I should -- I
15 should make clear that there are some pending
16 judicial challenges in those states, and so
17 their laws are not always enforceable or in
18 effect right now.

19 JUSTICE BARRETT: Besides Texas, has
20 the federal government -- has the federal
21 government brought suits similar to the one
22 brought in Idaho and Texas in any of these other
23 states?

24 GENERAL PRELOGAR: To be clear, Texas
25 was not our --

1 JUSTICE BARRETT: Right. Yeah.

2 GENERAL PRELOGAR: -- affirmative
3 litigation. They sued us. But we have not
4 brought affirmative litigation in other states.
5 And I think it's -- this case has been on a
6 course and Idaho's law was particularly severe
7 because, at the point at which we sued, it
8 seemed to cover ectopic pregnancy, and the state
9 conceded that. Now they have modified the law
10 to exclude that, but it was one of the most
11 pressing concerns because of that.

12 JUSTICE BARRETT: Thank you.

13 CHIEF JUSTICE ROBERTS: Justice
14 Jackson?

15 JUSTICE JACKSON: General, Petitioner
16 relies pretty heavily on clear statement rule
17 principles, and I wonder whether you might
18 comment on my thought that those principles
19 actually cut against them in this case.

20 As you said, Congress set a baseline
21 national standard of care. It has said in no
22 uncertain terms that the hospital must provide
23 stabilizing care to people experiencing
24 emergency medical conditions. There was no, as
25 you've said, you know, particular conditions --

1 or particular treatments talked about, carved
2 out, et cetera.

3 So, if a clear statement is required,
4 wouldn't it be the requirement of exemption --
5 of exempting abortion? I mean, you know,
6 Justice Alito has talked about some of the
7 references to unborn child, but none of them
8 read like an exemption that I would think our
9 clear statement rule would require in a
10 circumstance in which the baseline is this clear
11 national standard of care.

12 GENERAL PRELOGAR: Yes. I agree. I
13 think that Congress clearly was requiring
14 stabilization and made that an unqualified
15 mandate. It wasn't exempting particular
16 conditions or particular type of treatments.
17 And, you know, this Court has said that there's
18 no canon of donut holes. That was in Bostock,
19 that when you have a -- a provision like that,
20 the fact that you don't have a specific
21 enumeration of one of its applications doesn't
22 mean that you should read in some kind of
23 implicit exception.

24 So I think --

25 JUSTICE JACKSON: And if we're looking

1 for something clear, we would need to see, I
2 would think, the clear statement that Congress
3 meant for you not to have to provide an abortion
4 pursuant to the mandate of providing stabilizing
5 care.

6 GENERAL PRELOGAR: Yes. And I think
7 it's important to recognize that every relevant
8 actor has understood the statute this way from
9 the beginning. They understood Congress's clear
10 mandate here.

11 This has been the agency's position
12 all along. We are not adopting a new position.
13 That's reflected in our enforcement activity and
14 in HHS's guidance and rulemakings in this area.

15 Providers have understood it. Even
16 those hospitals that don't provide elective
17 abortions, they have always provided
18 life-sustaining and health-sustaining pregnancy
19 termination consistent with EMTALA.

20 Congress itself recognized it in the
21 Affordable Care Act. And I don't think there's
22 any reasonable argument to be made that people
23 misunderstood what Congress was doing in this
24 statute.

25 JUSTICE JACKSON: Thank you.

1 CHIEF JUSTICE ROBERTS: Thank you,
2 counsel.

3 Rebuttal, Mr. Turner.

4 REBUTTAL ARGUMENT OF JOSHUA N. TURNER
5 ON BEHALF OF THE PETITIONERS

6 MR. TURNER: Thank you, Your Honors.

7 EMTALA takes state law practice of
8 medicine standards as it finds them. As Justice
9 Gorsuch noted, that's what Section 1395 says.
10 And, in fact, in the vaccine mandate case that
11 was referenced, that's what the Solicitor
12 General's office told this Court when it said
13 that 1395 does not require -- does not allow
14 federal officials to dictate particular
15 treatments for particular cases.

16 That's exactly what they are trying to
17 do here with EMTALA. It's also confirmed by
18 subdivision (f). That -- that codifies a
19 presumption against preemption. And so, to
20 Justice Jackson's colloquy at the end, that is
21 the point. You do presume that state law
22 continues to operate alongside EMTALA. You
23 don't presume the opposite.

24 It's supported by the CMS operations
25 manual, which is HHS's Rosetta Stone of EMTALA

1 enforcement. It tells doctors, it tells CMS
2 enforcement agents on the ground that you
3 consider what is available by referencing what
4 is within the scope of that doctor's license.
5 That is exactly what we are saying.

6 It is also specifically directed in 42
7 C.F.R. 489.11, which requires hospitals to
8 assure that their medical staff comply with
9 state law. That's a federal regulation that
10 directs hospitals to require their hospital
11 staff to comply with state law.

12 It's also confirmed by the 115,000
13 enforcement instances that totally lack any
14 theory that would support, any case history that
15 would support the administration's reading. She
16 says that this has always been understood to be
17 the case. Well, you'd think that we would find
18 in those 115,000 instances a single example
19 where state law was overridden by EMTALA, and
20 there isn't one.

21 Finally, the text. The text qualifies
22 EMTALA's stabilization requirement by the staff
23 that is available. We know nurses can't perform
24 open heart surgery and we know janitors can't
25 draw blood. It's not just a plain mandate

1 devoid of reference to state law.

2 And we know the word "available" even
3 in a common usage incorporates state law. For
4 example, you heard just the other day that when
5 considering whether a bed is available for
6 homeless people, it has both a physical sense
7 and a legal sense. And whether cigarettes or
8 alcohol are available to people in Idaho, there
9 is both a physical question and a legal
10 question.

11 Opioids are available in hospitals.
12 They are on the shelf. They are physically
13 there. But there is a legal question that comes
14 into play too. It is the same with abortions.

15 In response to the Chief Justice's
16 question on conscience, General Prelogar said
17 that both hospitals and doctors are exempt from
18 EMTALA's supposed abortion mandate. We're
19 relieved to hear that. But I think that it
20 highlights the utter inconsistency of the
21 administration's reading.

22 So, if EMTALA's stabilization
23 requirement is general enough not to override
24 extratextual protections like conscience
25 protections, then it cannot be so specific and

1 include a requirement that is in direct conflict
2 with state law. Those two don't jibe.

3 This Court does not lightly find a
4 direct conflict. Congress must speak clearly.
5 It has not done so here.

6 The administration's position
7 ultimately is untethered from any limiting
8 principle. I think we heard that. There's just
9 no way to limit this to abortion. And there's
10 no way to limit it to Idaho. There are 22
11 states with abortion laws on the books. This
12 isn't going to end with Idaho. It's not going
13 to end with the six states that General Prelogar
14 mentioned because all of the states that have
15 abortion regulations define the health and the
16 emergency exception narrower than EMTALA does.
17 So this question is going to come up in state
18 after state after state.

19 It's also not limited to physical
20 health. I know General Prelogar says that
21 there's no circumstance in which a health -- a
22 mental health condition would require
23 stabilization with an abortion, but now she's
24 just fighting with the American Psychiatric
25 Association, the very standards that she's

1 setting up to say controls the EMTALA inquiry.
2 That's not consistent, and it isn't limited to
3 -- limited to EMTALA.

4 Justice Thomas, Alito, Justice
5 Gorsuch, you all pointed out the major Spending
6 Clause implications that are at play here. And
7 I disagree that we didn't brief this. It's on
8 pages 20 to 21 of our opening brief. We
9 recognize that this is hugely concerning if the
10 federal government can pay private actors to
11 violate state laws and not just any state laws,
12 state criminal laws. The implications of that
13 are vast. It leaves the federal government
14 unbound by enumerated powers. And I think
15 General Prelogar admitted that.

16 The Court doesn't have to answer that
17 question on our reading. It does on theirs.

18 CHIEF JUSTICE ROBERTS: Thank you,
19 counsel. The case is submitted.

20 (Whereupon, at 11:57 a.m., the case
21 was submitted.)

22

23

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Official - Subject to Final Review

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| <p style="text-align: center; margin: 0;">1</p> <p>10 [1] 95:12 10:03 [2] 1:21 4:2 11:57 [1] 131:20 115,000 [3] 36:10 128:12, 18 127 [1] 3:9 1395 [6] 4:22 16:5 99:12 100:6 127:9,13 14 [1] 26:10 15 [2] 95:15,20 16 [1] 24:9 17 [1] 114:25 1986 [3] 4:12 120:9,23 1989 [2] 44:1 105:6</p> <hr/> <p style="text-align: center; margin: 0;">2</p> <p>2 [1] 36:9 20 [1] 131:8 2008 [1] 88:10 2023 [1] 46:13 2024 [1] 1:17 21 [1] 131:8 22 [2] 23:3 130:10 23-726 [1] 4:4 24 [1] 1:17 27 [1] 26:12</p> <hr/> <p style="text-align: center; margin: 0;">3</p> <p>36 [1] 13:24</p> <hr/> <p style="text-align: center; margin: 0;">4</p> <p>4 [1] 3:4 42 [1] 128:6 46 [2] 67:15 71:16 489.11 [1] 128:7</p> <hr/> <p style="text-align: center; margin: 0;">5</p> <p>5 [3] 45:22 46:9 50:15 594 [1] 103:11</p> <hr/> <p style="text-align: center; margin: 0;">6</p> <p>615 [1] 103:12 617 [1] 103:13 64 [1] 3:6</p> <hr/> <p style="text-align: center; margin: 0;">8</p> <p>8 [3] 45:8 119:18 120:5</p> <hr/> <p style="text-align: 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