APPEAL NOS. 23-35440, 23-35450

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

STATE OF IDAHO,

Defendant-Appellant,

v.

MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE,

Movants-Appellants.

On Appeal from the United States District Court
for the District of Idaho
Case No. 1:22-cv-00329-BLW

REPLACEMENT OPENING BRIEF OF APPELLANT STATE OF IDAHO

JAMES A. CAMPBELL
JOHN J. BURSCH
ERIN M. HAWLEY
LINCOLN DAVIS WILSON
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001
(202) 393-8690
jcampbell@ADFlegal.org
jbursch@ADFlegal.org
ehawley@ADFlegal.org
lwilson@ADFlegal.org

RAUL R. LABRADOR
ATTORNEY GENERAL

ALAN M. HURST
SOLICITOR GENERAL
MICHAEL A. ZARIAN
700 W Jefferson St #210
Boise, ID 83720
(208) 332-3548
alan.hurst@ag.idaho.gov
michael.zarian@ag.idaho.gov

Counsel for Appellant State of Idaho

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STATEMENT REGARDING ORAL ARGUMENT

This case involves important questions of federal power and preemption, and the Court will benefit from the elucidation of these issues at oral argument. The Court has already indicated that en banc oral argument will take place during the week of December 9, 2024, in Pasadena, California.

STATEMENT OF JURISDICTION

The United States filed suit against the State of Idaho on August 2, 2022, asserting preemption under the United States Constitution and seeking a preliminary injunction. 3-StateER-369–85. The district court had jurisdiction under 28 U.S.C. § 1331. On August 24, 2022, the district court granted the United States a preliminary injunction. 1-StateER-51. Such an order is immediately appealable to this Court. 28 U.S.C. § 1292(a)(1).

On September 21, 2022, the State of Idaho moved to reconsider the preliminary injunction. 3-StateER-146–78. The motion was timely filed within 28 days of the preliminary injunction order. Fed. R. Civ. P. 59(e). On May 4, 2023, the district court denied the motion. 1-StateER-002–13.

On June 28, 2023, the State of Idaho filed a timely notice of appeal, *see* Fed. R. App. P. 4(a)(4)(A)(iv), which was docketed as Case No. 23-35440. On July 20, 2023, this appeal was consolidated with the Idaho legislature's appeal in *United States v. Moyle*, Case No. 23-35450, and a stay of the injunction pending appeal was sought. A panel of this Court issued a published opinion granting a stay of the injunction pending appeal on September 28, 2023. The United States moved for emergency

reconsideration en banc on September 30, 2023, which this Court granted in an unreasoned order on October 10, 2023. The en banc Court denied the motion to stay pending appeal on November 13, 2023.

On November 20, 2023, Idaho and the legislature filed emergency applications for a stay with the Supreme Court, invoking 28 U.S.C. §§ 1254 (1) and 2101 (f). On January 5, 2024, the Supreme Court granted the applications, stayed the district court's injunction, and granted certiorari before judgment. The Supreme Court's jurisdiction rested on 28 U.S.C. §§ 1254 (1) and 2101 (e).

On June 27, 2024, the Supreme Court dismissed the writ of certiorari as improvidently granted, vacated the stay entered January 5, 2024, and remanded to this Court for further proceedings en banc. This Court directed the parties to submit supplemental briefs.

STATEMENT OF THE ISSUES

1. Whether Congress can preempt state law and regulate the practice of medicine in the states by using its spending power to enter into contracts with private hospitals.

2. Whether Congress has expressed an "intent to foreclose" equitable suits like the federal government's by providing a detailed enforcement scheme under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd.

3. Whether EMTALA, which requires Medicare-funded emergency rooms to treat all patients in need of emergency medical treatment, preempts Idaho's Defense of Life Act, Idaho Code § 18-622, which generally prohibits abortion except in cases of rape or incest or to save the mother's life.

4. Whether the district court's preliminary injunction is overbroad because it departs from EMTALA's text and does not incorporate the administration's concessions.

PERTINENT STATUTES AND REGULATIONS

An addendum containing all pertinent statutes was attached to the State of Idaho's Opening Brief, filed August 7, 2023, as Docket Entry No. 12-1 in Case No. 23-35440. 9th Cir. R. 28-2.7.

INTRODUCTION

The United States sued the State of Idaho, claiming its agreement with private hospitals somehow preempts the state's democratically enacted law. According to the administration, the federal Emergency Medical Treatment and Active Labor Act—known as EMTALA—requires Idaho hospitals that accept Medicare payments to offer abortions, even abortions that are prohibited by Idaho's Defense of Life Act. The district court enjoined the Defense of Life Act in part. For three reasons, this Court should reverse and vacate the injunction.

First, the Spending Clause does not authorize Congress to preempt state law simply by paying private parties to violate it. Spending Clause legislation is based on consent—states that accept Congress's money accept the strings attached—and the administration does not claim Idaho ever consented to EMTALA's conditions. Instead, it argues that by sending money to hospitals, Congress can regulate medical practice nationwide and exclude the states that have traditionally performed that role. This stunning expansion of Congress's spending power has never been endorsed by any court, and this Court should not be the first.

Second, the administration lacks an equitable cause of action. Federal courts cannot grant equitable relief when Congress expressed an "intent to foreclose" it. *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 328 (2015). And Congress has done that here by providing a statutory enforcement mechanism in EMTALA.

Third, the administration's newfound interpretation of EMTALA violates the text, structure, purpose, and history of the statute. "EMTALA does not mandate any specific type of medical treatment, let alone abortion." *Texas v. Becerra*, 89 F.4th 529,

542 (5th Cir. 2024), *petition for cert. filed*, No. 23-1026 (U.S. Apr. 1, 2024). Quite the opposite, EMTALA requires hospitals to prevent harm to an "unborn child" by stabilizing any threatening condition. That admonition belies any requirement that hospitals must provide abortions contrary to state law. Further, EMTALA does not preempt state standards of care, but incorporates them. Before this lawsuit, the federal government had never construed the statute otherwise, and certainly not to mandate abortion.

At a minimum, this Court should vacate or narrow the district court's injunction. For one, the injunction cannot stand because the administration has not shown any circumstance where Idaho law prohibits an abortion that EMTALA allegedly requires. For another, the administration clarified EMTALA's limited scope before the Supreme Court: the Solicitor General represented that the stabilizing care required by EMTALA applies only to "acute" physical emergencies and not "mental health conditions." The administration also conceded that doctors and hospitals are protected if they object to providing abortions on conscience grounds.

In *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215, 232 (2022), the Supreme Court "return[ed] the issue of abortion to the people's elected representatives." To honor that principle and our federalist system of government, the en banc Court should reverse and vacate the district court's preliminary injunction.

STATEMENT OF THE CASE

I. Idaho protects unborn children.

In 2020, Idaho enacted a statute now known as the Defense of Life Act, which prohibits most abortions with exceptions for rape or incest and to protect the life of the mother. Idaho Code § 18-622. That Act became effective after *Dobbs* restored to the states the authority to regulate abortion. 597 U.S. at 292; H.B. 1385, 65th Leg., 2d Reg. Sess., 2020 Idaho Sess. Laws 827. As originally enacted, the Act created an affirmative defense for a physician performing an abortion where the "abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(i)–(iii) (2020).

After the district court entered its preliminary injunction here, the Idaho Supreme Court upheld the Defense of Life Act against a state-law challenge. *Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1203 (Idaho 2023). The Idaho Supreme Court clarified that removing an ectopic pregnancy is not an abortion under the Act, that the Act does not require "certainty" or imminency of a threat to the mother's life, and that the Act allows physicians to rely on their good-faith medical judgment on that question. *Id.* at 1202–03. The Idaho legislature then amended the Act to codify the Idaho Supreme Court's clarification on ectopic pregnancies and to recharacterize the Act's "life-saving" language as an exception to the Act's abortion prohibition rather than an affirmative defense. Idaho Code § 18-622 (2023).

II. EMTALA protects indigent patients and unborn children.

Congress enacted and President Reagan signed EMTALA into law nearly 40 years ago as part of the Medicare Act. The law addressed a specific concern: "that

hospitals were dumping patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients' conditions stabilized." *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001) (citing H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605). The Act is "commonly known as the 'Patient Anti-Dumping Act.'" *Id.*; *Marshall ex rel. Marshall v. E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) (emergency rooms were "refusing to treat patients who are unable to pay").

Consistent with that purpose, EMTALA imposes three duties on hospitals that accept Medicare. These duties apply when an "individual" presents in the emergency room. Following statutory amendments in 1989, each of those duties also embraces a duty to what EMTALA calls "the unborn child."

Screening. First, hospitals must conduct "an appropriate medical screening examination within the capability of the hospital's emergency department … to determine whether" the individual has an "emergency medical condition." 42 U.S.C. § 1395dd(a). EMTALA defines "emergency medical condition" in a manner that protects unborn life. It is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman *or her unborn child*) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part[.]"

42 U.S.C. § 1395dd(e)(1)(A) (emphasis added).

Stabilization. If the hospital determines the individual has an "emergency medical condition," it must "stabilize" that condition. To "stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. § 1395dd(e)(3)(A). EMTALA restricts a hospital's treatment obligation to what is "within the staff and facilities *available at the hospital*." 42 U.S.C. § 1395dd(b)(1)(A) (emphasis added). CMS has defined "available" as limited both by the hospital's physical space and "specialized services," as well as the "*scope of [its staff's] professional licenses*." Centers for Medicare & Medicaid Services (CMS), State Operations Manual, App. V, at 48, https://perma.cc/L499-GU4C (State Operations Manual) (emphasis added).

Transfer. As an alternative to stabilization of an emergency medical condition, a hospital may "transfer … the individual to another medical facility. 42 U.S.C. § 1395dd(b)(1). Transfers under EMTALA must also ensure that expected benefits outweigh the risks to "the individual and, in the case of labor, *to the unborn child*." 42 U.S.C. § 1395dd(c)(1)(A)(ii), (c)(2)(A) (emphasis added). Transfers are not "appropriate" unless they "minimize[ ] the risks to the individual's health and, in the case of a woman in labor, the health *of the unborn child*." *Id.* § (c)(2)(A) (emphasis added).

For its entire history, courts have correctly read EMTALA consistent with its anti-dumping purpose. *Bryant v. Adventist Health System/W.*, 289 F.3d 1162, 1166 (9th

Cir. 2002). And because EMTALA requires only the care "available" at the hospital, 42 U.S.C. § 1395dd(b)(1), "there is no question" the statute "does not [always] require an 'appropriate' stabilization." *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 253 (1999) (per curiam).

In sum, as CMS has long maintained, the text of EMTALA leaves the question of specific treatments for stabilizing care to state law and what is permitted by state medical licenses. State Operations Manual, App. V at 48.

III. EMTALA defers to state-law medical standards.

States license and regulate medical providers "under their police powers" for "the protection of the lives, limbs, health, comfort, and quiet of all persons." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (citation omitted). That is just as true for abortion, Idaho Code § 18-622, as it is for opioid and other pharmaceutical prescriptions, Idaho Code § 37-2705.

States also retain the authority to protect the integrity and ethics of the medical profession. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997). That reserved power is inherent in "the structure and limitations of federalism." *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006). EMTALA operates against that backdrop of state regulation. Indeed, any preemption analysis starts with the "assumption that the historic police powers of the States"—including their power to impose medical standards of care—do not yield to federal law apart from "the clear and manifest purpose of Congress." *Medtronic*, 518 U.S. at 485 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). And the Medicare Act's savings clause clarifies that EMTALA does not override state regulation of medicine: "[n]othing in this subchapter"—including EMTALA—"shall

be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395.

IV. The United States reinterprets EMTALA as an abortion mandate.

In the immediate aftermath of *Dobbs*, President Biden issued an executive order directing multiple agencies—including HHS, the Department of Justice, the Secretary of Homeland Security, and the Federal Trade Commission—to undertake a government-wide effort to use federal law to "promote" abortion. Protecting Access to Reproductive Healthcare Services, Exec. Order No. 14076, 87 Fed. Reg. 42053, 42053–54 (July 8, 2022). The President's directive called on his administration to "consider[ ] updates to current guidance on obligations specific to emergency conditions and stabilizing care under" EMTALA. 87 Fed. Reg. at 42054.

Three days after the executive order, the administration discovered a new national abortion mandate in EMTALA, where it had evidently lain dormant for 36 years. HHS issued novel "guidance" to "remind" hospitals receiving Medicare funds of a position it had never before taken: that EMTALA requires emergency room doctors to perform or complete abortions, including "incomplete" chemical-induced abortions, regardless of state laws that would bar them. CMS, *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* 1, 6 (July 11, 2022).

The memorandum insists that if "a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by

EMTALA, and … abortion is the stabilizing treatment necessary to resolve that condition, the physician *must* provide that treatment." *Id.* at 1. Never before had guidance on EMTALA required hospitals or physicians to provide any particular procedure, much less an abortion. The memorandum also insisted that "[a]ny state actions against a physician who provides an abortion in order to stabilize an emergency medical condition [as defined by that physician] in a pregnant individual presenting to the hospital would be preempted." *Id.* at 5–6. And the administration threatened that if a hospital terminates its Medicare provider agreement to avoid this reinterpretation of EMTALA, CMS may penalize the hospital. *Id.* at 4.

V. The district court grants an injunction and Idaho appeals.

Three weeks after the new CMS guidance was issued, the United States sued Idaho. *United States v. State of Idaho*, No. 1:22-cv-00329-BLW, 3-StateER-369–85. It sought declaratory relief that Idaho Code § 18-622 "violates the Supremacy Clause and is preempted to the extent it is contrary to EMTALA." 3-State-ER-383. The federal government also asked for an injunction. 3-StateER-288–316. The Idaho legislature was awarded intervention. 3-StateER-286–87.

The district court granted a preliminary injunction. 1-StateER-014–52. It held that the Defense of Life Act was preempted by EMTALA for abortions 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." 1-StateER-052.

The State and the legislature moved for reconsideration. While those motions were pending, the Idaho Supreme Court interpreted the Defense of Life Act. *Planned Parenthood Great Nw.*, 522 P.3d at 1202–03. Thereafter, the legislature amended the Act, clarifying that the treatment for ectopic pregnancy was not an abortion and converting the life-of-the-mother affirmative defense into a statutory exception. Idaho Code § 18-622(2)(a)(i). The district court nevertheless denied reconsideration. 1-StateER-012.

The State and the legislature appealed and requested a stay. A unanimous Ninth Circuit panel granted a stay in a published order, concluding that "EMTALA does not preempt" Idaho's Defense of Life Act. *United States v. Idaho*, 83 F.4th 1130, 1134 (9th Cir. 2023). The panel first determined that conflict preemption did not exist. EMTALA "does not set standards of care or specifically mandate that certain procedures, such as abortion, be offered." *Id.* at 1135. And Congress did not intend EMTALA to supersede "the historic police powers of the States," including the right to prohibit abortion. *Id.* at 1136 (citation omitted). The panel also held that obstacle preemption was inapplicable: the Act's "limitations on abortion services do not pose an obstacle to EMTALA's purpose because they do not interfere with the provision of emergency medical services to indigent patients." *Id.* at 1138–39.

Within days and without explanation, the en banc Court vacated the panel's stay opinion and granted en banc review. The State and the legislature then moved the Supreme Court for a stay pending appeal or in the alternative for a writ of certiorari before judgment.

VI. The Supreme Court grants certiorari and then dismisses it.

On January 5, 2024, the Court granted the stay and the petition in both cases. *Idaho v. United States*, 144 S. Ct. 541 (2024). However, on June 27, 2024, the Supreme Court dismissed the writs of certiorari as improvidently granted and remanded to this Court. *Moyle v. United States*, 144 S. Ct. 2015 (2024). Justice Barrett concurred, noting that the United States made significant concessions regarding its position before the Supreme Court. *Id.* at 2021. For one, it "emphatically disavowed the notion that an abortion is ever required as stabilizing treatment for mental health conditions." *Id.* Moreover, "the United States clarified that federal conscience protections, for both hospitals and individual physicians, apply in the EMTALA context." *Id.* And it conceded that EMTALA requires delivery of an unborn child post-viability and stated that EMTALA would require abortion only in acute situations. *Id.* at n.*.

In dissent, Justice Alito, joined by Justices Thomas and Gorsuch, would have ruled in Idaho's favor on the merits. In their view, the federal government's "preemption theory is plainly unsound." *Id.* at 2027. And "Idaho never consented to *any* conditions imposed by EMTALA and certainly did not surrender control of the practice of medicine and the regulation of abortions within its territory." *Id.* at 2028.

VII. After remand, the administration reaffirms its EMTALA guidance.

Two business days after the Supreme Court dismissed this case, the administration issued new guidance reaffirming its interpretation of EMTALA. *See* Press Release, U.S. Dep't of Health & Hum. Servs., *Biden-Harris Administration Reaffirms Commitment to EMTALA Enforcement* (July 2, 2024), https://perma.cc/ZEV4-ENKY (Becerra Ltr.). The administration's new guidance, which threatened

termination of provider agreements for non-compliance, did not mention any of the concessions the administration made before the Supreme Court. *Id.* Idaho requested that the administration agree to modify the injunction based on those concessions, but the administration declined to do so. Idaho's motion for that relief from the district court remains pending.

SUMMARY OF ARGUMENT

In EMTALA's nearly 40-year history, no one thought it required abortion until the administration sought to recreate a federal abortion mandate after *Dobbs*. But nothing in EMTALA's text or history suggests that it preempts Idaho's Act.

This Court need not even reach that question. It is undisputed that Idaho never agreed to EMTALA's terms; it has no public hospitals that have taken Medicare funding. The federal government's theory is based entirely on agreements with *private* hospitals. In other words, the administration says that Idaho law is preempted because someone else contracted with the federal government. That theory of EMTALA obliterates both the knowing and voluntary limitations on the spending power. And it makes a mockery of our federalist system, which has never been understood to require the states to govern at Congress's direction. Indeed, no court has held that the United States can preempt state laws—and thereby regulate the practice of medicine—merely by entering into contracts with private parties. This Court should not take that dramatic step.

In addition, the administration lacked a cause of action to sue Idaho for an injunction. As the Supreme Court has recognized, federal courts cannot grant equitable relief when Congress expressed an "intent to foreclose" it. *Armstrong*, 575

U.S. at 328. Congress has done that here by creating a carefully reticulated enforcement mechanism in EMTALA. That forecloses the grant of equitable relief.

The merits of the administration's preemption claim also fail. No less than three canons of construction require the administration to show that Congress clearly included an abortion mandate in EMTALA. It did not. To the contrary, the statute protects "the unborn child" and requires that hospitals provide only those services "available" at their facilities. Reinforcing this text, the statute has never been construed to mandate a national standard of care or a particular medical treatment. Instead, it requires hospitals to treat patients equally regardless of their ability to pay.

At minimum, the Court should narrow the injunction to reflect EMTALA's text and the United States' concessions at the Supreme Court.

STANDARD OF REVIEW

When a district court issues a preliminary injunction on "faulty legal premises," the injunction must be vacated. *All. for the Wild Rockies v. Petrick*, 68 F.4th 475, 483 (9th Cir. 2023) (reversing grant of preliminary injunction). An injunction will not stand unless the district court "got the law right." *Id.* at 491. Accordingly, this Court reviews the district court's conclusions of law de novo. *Id.* It reviews the other terms of the preliminary injunction for an abuse of discretion. *A&M Records, Inc. v. Napster, Inc.*, 284 F.3d 1091, 1096 (9th Cir. 2002).

A preliminary injunction is an "extraordinary remedy." *California ex rel. Becerra v. Azar*, 950 F.3d 1067, 1105 (9th Cir. 2020) (citation omitted). It "should not be granted unless the movant, by a clear showing, carries the burden of persuasion." *Towery v. Brewer*, 672 F.3d 650, 657 (9th Cir. 2012) (per curiam) (citation omitted). Here, the

United States must establish the following four factors: "(1) it is likely to prevail on the merits of its substantive claims, (2) it is likely to suffer imminent, irreparable harm absent an injunction, (3) the balance of equities favors an injunction, and (4) an injunction is in the public interest." *Petrick*, 68 F.4th at 490 (citation omitted). Since the party opposing the preliminary injunction is a state government, the third and fourth factors merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009).

This Court applies the same standard of review to the district court's decision denying the State's motion for reconsideration. *Trader Joe's Co. v. Hallatt*, 835 F.3d 960, 965–66 n.3 (9th Cir. 2016).

ARGUMENT

I. The federal government cannot override state law by paying private parties to violate it.

The administration argues that the Spending Clause permits third-party hospitals to bind nonconsenting States to conditions to which they never agreed and thereby preempt state law. That breathtaking view of the spending power is both unprecedented and baseless.

To be sure, "objectives not thought to be within Article I's enumerated legislative fields, may nevertheless be attained through the use of the spending power and the conditional grant of federal funds." *South Dakota v. Dole,* 483 U.S. 203, 207 (1987) (cleaned up). The spending power, in other words, allows Congress to "induce the States to adopt policies that the Federal Government itself could not impose." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 537 (2012) (opinion of Roberts, C.J.).

Yet that power does not change the fundamental bargain agreed to by ratifying States: "The powers of the legislature are defined, and limited; and that those limits may not be mistaken, or forgotten, the constitution is written." *Marbury v. Madison,* 5 U.S. (1 Cranch) 137, 176 (1803). The Supreme Court has thus repeatedly recognized "limits on Congress's power under the Spending Clause to secure state compliance with federal objectives." *Sebelius*, 567 U.S. at 576 (opinion of Roberts, C.J.).

To begin, Spending Clause legislation functions "in the nature of a contract: in return for federal funds, the recipients agree to comply with federally imposed conditions." *Barnes v. Gorman,* 536 U.S. 181, 186 (2002) (cleaned up) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). "The legitimacy of Congress's exercise of the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Sebelius*, 567 U.S. at 577 (opinion of Roberts, C.J.) (cleaned up). "Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *Id.*

Here, there's no question that EMTALA is Spending Clause legislation. It conditions Medicare funds on a hospital's compliance with certain conditions. In particular, EMTALA requires participating hospitals—in exchange for federal monies—to provide stabilizing treatment for certain emergency medical conditions, irrespective of the patient's insurance or ability to pay. 42 U.S.C. § 1395dd. Consistent with the nature of spending power legislation, the statute's terms bind only participating hospitals, not third parties like Idaho. *Id.* §§ 1395dd(e)(2), 1395cc.

A. The administration's view of EMTALA violates the clear-notice requirement.

The Spending Clause's clear-notice requirement ensures that a State knowingly accepts federal conditions. It mandates that—to be binding—a condition must be set out "unambiguously." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). In fact, the Supreme Court has long held that "[t]here can … be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it." *Pennhurst*, 451 U.S. at 17–18. Additionally, Congress may not change the terms of the bargain through a post-acceptance "surpris[e]." *Id.* at 25. Such a modification would negate the requirement that States knowingly consent to federal conditions on the front end.

Here, Idaho never knowingly agreed to be bound by EMTALA, much less the administration's novel interpretation of that law. It has no public hospitals that accept Medicare funding. That's why the United States conceded at oral argument that Idaho never accepted EMTALA's conditions. Oral Arg. Tr. at 70–71, *Moyle v. United States*, No. 23-276 (April 24, 2024) (Oral Arg. Tr.). That should end the matter. The spending power cannot preempt state law absent a "knowing[ ]" acceptance. *Sebelius*, 567 U.S. at 577 (opinion of Roberts, C.J.).

The administration insists that it doesn't matter that Idaho never knowingly agreed to the conditions because *someone else* did. Under that erroneous view of the Spending Clause, the administration's agreements with private hospitals bind Idaho, too. But a third-party hospital's acceptance of Spending Clause conditions can no more bind Idaho than could New York's acceptance of conditions bind Missouri.

B. The administration's view of EMTALA violates the non-coercion requirement.

A state's acceptance of Spending Clause conditions must be voluntary. *Sebelius*, 567 U.S. at 577 (opinion of Roberts, C.J.) (cleaned up). Under the anti-coercion doctrine, courts "scrutinize Spending Clause legislation to ensure that Congress is not using financial inducements to exert a power akin to undue influence" over the States. *Id.* at 577 (opinion of Roberts, C.J.) (cleaned up). Such legislation may not cross the "point at which pressure turns into compulsion, and ceases to be inducement." *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937). In contrast, where states exercise their "unfettered will" and accept federal conditions, they may not later raise Spending Clause concerns. *Id.* at 590.

In *South Dakota v. Dole*, for instance, the Supreme Court held that Congress had validly used the spending power to incentivize states to accept a federally imposed minimum drinking age. Because the financial incentive—less than one percent of the State's budget—was "relatively mild encouragement," 483 U.S. at 211, the decision whether to accept the federal drinking age condition "remain[ed] the prerogative of the States not merely in theory but in fact." *Id.* at 211–12. In short, South Dakota's acceptance of the condition was voluntary.

The anti-coercion doctrine dooms the administration's preemption claim here. If the government may not exert "undue influence" on a state's choice to accept federal conditions, it certainly cannot deprive states of any choice at all. Here, far from exercising its "unfettered will" to voluntarily agree to EMTALA's conditions, *Steward Mach.*, 301 U.S. at 590, Idaho never accepted those terms at all.

According to the administration, the anti-coercion principle does not apply here because a state law effectively vanishes when the federal government pays a third party to violate it. That cannot be. To take one example, suppose the federal government wanted to lower the drinking age to 18 nationwide. Under that theory, Congress could condition payments to liquor stores on their agreement to provide alcohol to anyone over 18, and states would have no say.

The administration's claim that third-party agreements override state law makes spending power limitations wholly illusory. Indeed, the administration told the Supreme Court that the spending power gives the federal government the authority to regulate the practice of medicine in every state. Oral Arg. Tr. at 98. All the federal government has to do, it says, is pay private hospitals. And it acknowledged the implications of this view: through this mechanism, the spending power would allow the government to ban abortion or prohibit gender-reassignment surgeries for minors nationwide—or alternatively, to require abortions or gender-reassignment surgeries nationwide. *Id.* at 97. So much for "the historic primacy of state regulation of matters of health and safety." *Medtronic*, 518 U.S. at 485. The government's extraordinary view of the spending power would vastly "undermine the status of the States as independent sovereigns in our federal system." *Sebelius*, 567 U.S. at 577(opinion of Roberts, C.J.).

To allow a private party to bind Idaho to federal terms "runs contrary to our system of federalism." *Id.* at 577–78 (opinion of Roberts, C.J.). Courts reasonably expect "the States to defend their prerogatives by adopting 'the simple expedient of not yielding' to federal blandishments when they do not want to embrace the federal

policies as their own." *Id.* at 579 (opinion of Roberts, C.J.) (quoting *Massachusetts v. Mellon*, 262 U.S. 447, 482 (1923)). But the "Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions." *New York v. United States*, 505 U.S. 144, 162 (1992).

In short, the administration's argument fails because Idaho never agreed to EMTALA's conditions and cannot possibly be bound by them. The federal government is wrong that it may purchase *state* compliance by paying *private* parties for it. To hold otherwise "would present a grave threat to the system of federalism created by our Constitution." *See Sebelius*, 567 U.S. at 675 (joint dissent of Scalia, Kennedy, Thomas, and Alito, J.J.).

C. The administration's cited authorities in favor of third-party preemption fall far short of the mark.

The administration has previously asserted that "valid Spending Clause legislation is federal 'Law[ ]' entitled to full preemptive force under the Supremacy Clause." Br. for Resp't at 45, *Moyle v. United States*, No. 23-726 (U.S. Mar. 21, 2024) (U.S. Br.). Yet the federal courts have recognized the fundamental "awkwardness" of basing preemption on legislation enacted under the spending power. *O'Brien v. Mass. Bay Transp. Auth.*, 162 F.3d 40, 43 (1st Cir. 1998). This is because the terms of such legislation are knowingly and voluntarily accepted. Thus, the "typical remedy for state noncompliance with federally imposed conditions is … to terminate funds." *Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166, 183 (2023). At most, Spending Clause legislation could preempt state law only where "the State voluntarily and

knowingly accepts the terms of the 'contract.'" *Sebelius*, 567 U.S. at 577 (opinion of Roberts, C.J.) (cleaned up). Here, Idaho never agreed to EMTALA.

The administration has gestured towards a handful of cases it says supports its argument that private-party agreements under the spending power preempt state law. U.S. Br. at 45–46 (citing *Coventry Health Care of Mo., Inc. v. Nevils*, 581 U.S. 87 (2017), *Bennett v. Arkansas*, 485 U.S. 395 (1988) (per curiam), *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256 (1985), *Philpott v. Essex County Welfare Bd.*, 409 U.S. 413 (1973), and *Townsend v. Swank*, 404 U.S. 282 (1971)). But none of those cases so held, as Justice Alito observed at oral argument. Oral Arg. Tr. at 71–72. These authorities merely conclude that states could not add conditions to federal programs like social security or federal employee disability insurance.

In any event, in none of the cited cases did the parties or the Supreme Court address the Spending Clause issue at all. Such rulings establish no precedent on the Spending Clause. *Brecht v. Abrahamson*, 507 U.S. 619, 631 (1993) ("[S]ince we have never squarely addressed the issue, and have at most assumed the [issue], we are free to address the issue on the merits.").

The administration has also made the counterintuitive argument that EMTALA's *savings* clause supports preemption. That Congress *limited* the preemptive effect of EMTALA—providing that state law is not preempted unless it "directly conflicts" with EMTALA, 42 U.S.C. § 1395dd—in no way suggests Congress can bind *nonconsenting* states. The Constitution's structural limitations still apply, and the federal government cannot bind a state by contracting with that state's citizens.

II. The administration lacks a cause of action.

The United States, like any plaintiff, must have a "cause of action." *Atlas Life Ins. Co. v. W. I. Southern, Inc.*, 306 U.S. 563, 570 (1939). Because the Supremacy Clause does not contain its own cause of action, the federal government resorts to equity. But Congress has expressed an "intent to foreclose" equitable suits under EMTALA by providing a detailed enforcement scheme under that statute. *Armstrong*, 575 U.S. at 328. So the administration's lawsuit fails at the starting gate.

A. There are adequate remedies at law.

Equitable relief is unavailable when there is an "adequate remedy at law." *Thompson v. Allen Cnty.*, 115 U.S. 550, 554 (1885). And the United States has adequate remedies to enforce EMTALA.

Congress has prescribed civil monetary penalties against EMTALA-offending hospitals and physicians and the power to exclude them from future participation in Medicare programs. 42 U.S.C. § 1395dd(d)(1). To pursue these statutory remedies, the government must follow a thorough process of administrative and judicial review. 42 U.S.C. § 1320a-7a. Within six years of an alleged violation, the HHS Secretary may "initiate an [enforcement] action." 42 U.S.C. § 1320a-7a(c)(1). The Secretary must then hold a "hearing," accept evidence, 42 U.S.C. § 1320a-7a(c)(2), and "determin[e] the amount or scope of any penalty," 42 U.S.C. § 1320a-7a(d). After judicial review, the Secretary may enforce in federal court the penalty imposed and allocate recovered funds consistent with statutory scheduling. 42 U.S.C. § 1320a-7a (e)-(f).

This detailed remedial scheme ensures that the federal government will be made whole if a grant recipient violates EMTALA. CMS knows well how to use its

statutory remedies; it is pursuing two such investigations against hospitals in Missouri. Press Release, U.S. Dep't of Health & Hum. Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023), https://perma.cc/NVW2-WJJZ. These statutory remedies afford the United States adequate enforcement tools. That it has refused to employ them here does not entitle it to sue in equity.

B. Available remedies are exclusive.

The remedies discussed above are also exclusive. "[T]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others." *Armstrong*, 575 U.S. at 328 (cleaned up); *accord*, *e.g.*, *Transamerica Mortg. Advisors, Inc. v. Lewis*, 444 U.S. 11, 19 (1979). Here, Congress has provided some enforcement methods and denied others—including injunctions. This careful balancing of remedies in EMTALA was deliberate, and federal courts "cannot … recognize a cause of action that Congress has denied." *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 128 (2014).

"Courts of equity can no more disregard statutory and constitutional requirements … than can courts of law." *I.N.S. v. Pangilinan*, 486 U.S. 875, 883 (1988) (quoting *Hedges v. Dixon Cnty.*, 150 U.S. 182, 192 (1893) (cleaned up)). Because available remedies "implicitly preclude[ ]" injunctions, the United States cannot invoke equity to "circumvent" Congress's choice. *Armstrong*, 575 U.S. at 328. That squarely forecloses the federal government's injunction request here.

III. EMTALA does not preempt state abortion laws.

Even if the federal government could override the laws of nonconsenting states vis-à-vis the spending power, and even if an equitable cause of action existed here, EMTALA does not preempt the Defense of Life Act. For the administration to prevail, EMTALA requires it to show a "direct[ ] conflict" with the Defense of Life Act. 42 U.S.C. § 1395dd(f). Under this standard, Idaho law is preempted only if compliance with both EMTALA and state law is "impossible," *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372–73 (2000), or if state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990) (citation omitted). Neither is true here.

The federal government's preemption argument presents a question of statutory interpretation. As always, that interpretation "begins with the text," *Ross v. Blake*, 578 U.S. 632, 638 (2016), as informed by "canons of statutory interpretation." *Sw. Airlines Co. v. Saxon*, 596 U.S. 450, 457 (2022). In addition to the text, the Court also considers the structure, purpose, and history of the statute. *Life Techs. Corp. v. Promega Corp.*, 580 U.S. 140, 149-50 (2017). These principles apply because preemption analysis "does not occur in a contextual vacuum" and "is informed by … presumptions about the nature of pre-emption." *Medtronic*, 518 U.S. at 484–85.

At the outset, the administration's interpretation faces three clear-statement canons that demand an unambiguous abortion requirement. But EMTALA's plain language excludes that reading, since it directs hospitals to care for "the unborn child." *See* 42 U.S.C. § 1395dd(e)(1)(A)(i). EMTALA's structure and purpose also foreclose that interpretation—the law incorporates state standards of care, and it was

enacted by a Congress and presidential administration that opposed federal subsidies of abortion. History, too, stands against the administration, which has not cited any instance in which EMTALA was ever construed to mandate abortion during the first 36 years after its enactment. The administration's aggressive new reading cannot prevail, and this Court should reverse.

A. Clear-statement canons foreclose the federal government's expansive reading of EMTALA.

The administration's attempt to construe EMTALA as an abortion mandate with preemptive force requires it to overcome the hurdles set by three different clear-statement canons: the presumption against preemption, the Spending Clause, and the major-questions doctrine. It cannot surmount any of these barriers, much less all of them.

1. The presumption against preemption forecloses an expansive reading of EMTALA.

Courts presume that Congress does not preempt state regulation of medicine. The preemption analysis starts "with the assumption that the historic police powers of the States [are] not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rice*, 331 U.S. at 230; *Wyeth v. Levine*, 555 U.S. 555, 565 (2009). This presumption "applies with particular force when Congress has legislated in a field traditionally occupied by the States," *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (2008), such as "health and safety" regulations where states have "historic primacy." *Medtronic*, 518 U.S. at 485.

As the Supreme Court has held, the regulation of medicine is "a field which the States have traditionally occupied," *Wyeth*, 555 U.S. at 565 & n.3 (citation omitted), and states have a deep interest "in protecting the integrity and ethics of the medical profession," *Glucksberg*, 521 U.S. at 731. If EMTALA is "susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Altria*, 555 U.S. at 77 (quoting *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)).

EMTALA reinforces these interpretive principles by baking them into its text. As part of the Medicare Act, EMTALA specifically disclaims any federal interference in the states' "control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395. Plus, EMTALA includes its own separate savings clause, which forbids preemption of state law absent a "direct[ ] conflict[ ]." 42 U.S.C. § 1395dd(f). These saving clauses mean EMTALA's preemptive effect must be construed "as narrowly as possible." *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (per curiam). The presumption against preemption requires the administration to show that its reading of EMTALA is clearly correct, something it cannot do.

2. The limitations inherent in Spending Clause legislation foreclose an expansive reading of EMTALA.

EMTALA's status as Spending Clause legislation imposes yet another clear-statement hurdle. Even if the federal government could override state law by paying a private party to violate it (and, as explained above, it cannot), the administration would still have to show that EMTALA imposed the condition it advocates "unambiguously." *Pennhurst*, 451 U.S. at 17.

The text of EMTALA does not provide "clear notice" of its purported abortion mandate. *See Murphy*, 548 U.S. at 296. It defers to state medical-practice standards and directs covered hospitals to provide care for the "unborn child." 42 U.S.C. § 1395dd(e)(1)(A)(i). "[N]o one who has any respect for statutory language can plausibly say that the Government's interpretation is *unambiguously* correct." *Moyle*, 144 S. Ct. at 2027–28 (Alito, J., dissenting, emphasis added).

3. The major questions doctrine forecloses an expansive reading of EMTALA.

Finally, the major-questions doctrine thwarts an expansive interpretation of EMTALA. The major-questions doctrine is based on "both separation of powers principles and a practical understanding of legislative intent." *West Virginia v. E.P.A.*, 597 U.S. 697, 723 (2022). It is rooted in the common-sense presumptions that "Congress intends to make major policy decisions itself," *id.* (citation omitted), does not "hide elephants in mouseholes," *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001), and refrains from settling important political issues using "cryptic" language, *West Virginia*, 597 U.S. at 721.

That framework applies here. Enacting an emergency-room mandate that overrides state-law standards of care—whether involving experimental medications, marijuana, or abortion—is a matter of undoubted "political significance." *Id.* And in the Supreme Court, the administration conceded that "when Congress intends to create special rules governing abortion …, it does so explicitly." Resp. in Opp. to Appl. for Stay at 33–34, *Moyle v. United States*, 144 S. Ct. 2015 (2024) (No. 23-727) (citations omitted). That is particularly clear given the "lack of historical precedent"

for invoking EMTALA to mandate abortions, *NFIB v. Dep't of Lab., Occupational Safety & Health Admin.*, 595 U.S. 109, 119–20 (2022) (per curiam), as well as "the sheer scope" of the government's capacious reading of the statute, *Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 594 U.S. 758, 764 (2021) (per curiam).

Thus, under major-questions principles, the Court should give a considerable "measure of skepticism" to the administration's claim that Congress mandated abortions without even using the word. *Util. Air Regul. Grp. v. E.P.A.*, 573 U.S. 302, 324 (2014). A "plausible" or "colorable textual basis" will not suffice. *West Virginia*, 597 U.S. at 722–23. Rather, the administration must (but cannot) point to "clear congressional authorization." *Id.* at 723.

B. EMTALA's plain text precludes reading it as an abortion mandate.

1. EMTALA imposes a duty to "the unborn child."

Under these clear-statement canons, EMTALA's plain language forecloses the administration's reading of the statute. EMTALA does not even mention abortion, much less require it. Quite the opposite: EMTALA demands that covered hospitals care for both "the woman" *and* "her unborn child." 42 U.S.C. § 1395dd(e)(1)(A)(i). The United States' attempt to cobble together an abortion mandate from a statute that disclaims it is "plainly unsound." *Moyle*, 144 S. Ct. at 2027 (Alito, J., dissenting).

There is no getting around the statutory duty to the unborn child, which is woven throughout EMTALA's screening, stabilization, and transfer requirements.

First, in screening for whether "an emergency medical condition … exists," 42 U.S.C. § 1395dd(a), EMTALA demands that Medicare-funded hospitals evaluate

whether the condition may "plac[e] ... the health of the woman or her unborn child ... in serious jeopardy." *Id.* § 1395dd(e)(1)(A)(i). EMTALA thus expressly references the health of the unborn child and requires providers to screen for conditions that place the child in jeopardy.

Second, if the child has such a condition, the hospital must "stabilize" the condition "within the staff and facilities available at the hospital." *Id.* § 1395dd(b)(1)(A). Notably, the duty is not to stabilize the patient, but to stabilize the *condition*, which again, includes a condition that places the child's health in "jeopardy." *Id.* § 1395dd(e)(1)(A)(i). "[A]borting an 'unborn child' does not protect it from jeopardy." *Moyle*, 144 S. Ct. at 2029 (Alito, J., dissenting).

Third, if a hospital chooses instead to transfer a pregnant woman in labor to another facility, it must again consider the unborn child. EMTALA requires the hospital to certify that the expected benefits of transfer outweigh any "increased risks" to the woman "and, in the case of labor, to the unborn child." 42 U.S.C. §§ 1395dd(c)(1)(A)(ii), (e)(1)(B). So "regardless of whether a hospital chooses to treat or transfer a pregnant woman, it must strive to protect her 'unborn child' from harm." *Moyle*, 144 S. Ct. at 2029 (Alito, J., dissenting).

Other contextual clues further dispel the notion that Congress intended EMTALA to function as an abortion mandate. EMTALA was bipartisan legislation that "garnered broad support in both Houses of Congress, including the support of Members such as Representative Henry Hyde who adamantly opposed the use of federal funds to abet abortion." *Moyle*, 144 S. Ct. at 2030–31 (Alito, J., dissenting). Similarly, President Ronald Reagan, who signed EMTALA into law, "repeatedly

promised not to use federal funds to subsidize or require the provision of abortions." *Id.* (citations omitted). It is not plausible to understand EMTALA as promoting an abortion mandate that its supporters vehemently opposed.

2. The United States cannot construe a duty to "the unborn child" as an abortion mandate.

According to the administration, EMTALA's "unborn child" language does not matter because the statute only imposes duties to the "individual," which does not include unborn children. *See* 1 U.S.C. § 8(a); U.S. Br. at 41. This is simply incorrect: EMTALA does not focus the stabilization duty on the individual, but rather demands that covered hospitals "stabilize *the medical condition*," which it expressly defines to include a condition that places "the health of the . . . unborn child[ ] in serious jeopardy." 42 U.S.C. §§ 1395dd(b)(1)(A), (e)(1)(A)(i) (emphasis added).

Even if the administration were correct about the original meaning of "individual," Congress expressly amended EMTALA to protect unborn children. The amendments provide that, if the "individual" is pregnant or in labor, the hospital must also consider the health of "the unborn child." 42 U.S.C. §§ 1395dd(c)(1)(A)(ii), (2)(A), (e)(1)(A)(i), (B)(ii). Again, the administration does not explain how an emergency room could, for example, "minimize[ ] the risks to … the health of the unborn child" by effecting a transfer to provide an abortion. 42 U.S.C. § 1395dd(c)(2)(A).

Even further, as Justice Alito observed, "there is a simple explanation for EMTALA's repeated use of the term 'individual,' and it provides no support for the Government's interpretation." *Moyle*, 144 S. Ct. at 2030 (Alito, J., dissenting). "Most

of those references involve conduct in which *only* the pregnant woman can engage, such as going to an emergency room, receiving medical information, consenting to or refusing treatment, or filing suit." *Id.* (emphasis added). In contrast, the references to "unborn child" involve situations in which the health of the child may be implicated along *with* the mother—e.g., "when a pregnant woman is transferred, her 'unborn child' obviously goes with her," and "a woman's 'emergency medical condition,' … includes conditions that jeopardize her 'unborn child.'" *Id.* Even if the administration's interpretation were plausible, the presence of an alternate reading that also protects the child precludes a finding of preemption.

The administration also argues that because EMTALA assigns the giving of "informed consent" to the individual, it means that a pregnant woman speaks for her child and can obtain an abortion in violation of state law. 42 U.S.C. § 1395dd(b)(2)-(3). But informed consent is itself a state-law legal doctrine, and the giving of informed consent thus necessarily cannot broaden the medical procedures that state law permits. Of course, "the right to refuse medical treatment without consent does not entail the right to demand treatment that is prohibited by law." *Moyle*, 144 S. Ct. at 2030 (Alito, J., dissenting). "[A] woman's right to withhold consent to treatment related to her pregnancy does not mean that she can demand an abortion." *Id.*

C. EMTALA's structure precludes the administration's view of the statute.

EMTALA's statutory structure makes the administration's reading even more untenable. The administration maintains that EMTALA imposes a federal standard of care that can require doctors to provide abortion in the emergency room regardless of

contrary state law. That conception flouts the basic premise of the entire Medicare Act. That Act insists, in its very first section, that the law "shall [not] be construed" to interfere with "the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395. This statutory provision "underscores the 'congressional policy against the involvement of federal personnel in medical treatment decisions.'" *Texas*, 89 F.4th at 542 (quoting *United States v. Univ. Hosp., State Univ. of N.Y. at Stony Brook*, 729 F.2d 144, 160 (2d Cir. 1984)).

That is why Congress prohibited the government from "direct[ing] or prohibit[ing] any [particular] kind of treatment or diagnosis" in administering Medicare, *Goodman v. Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989) (per curiam), and it conditioned hospitals' Medicare participation on "assur[ing] that personnel are licensed or meet other applicable standards that are required by State or local laws," 42 C.F.R. § 482.11(c). EMTALA's provisions do not displace state standards; they incorporate them. And in imposing its federal duty to treat, EMTALA takes state law as it finds it. The federal government's contrary view cannot stand.

1. EMTALA imposes a federal duty to treat, not a national standard of care.

The courts of appeals are unanimous in holding that EMTALA's federal rule is not a national standard of care. The Fifth Circuit recently rejected the administration's attempt to construe EMTALA as an abortion mandate, concluding that "EMTALA does not impose a national standard of care." *Texas*, 89 F.4th at 543. This Court has held the same: EMTALA "was not enacted to establish … a national standard of

care." *Bryant*, 289 F.3d at 1166. Indeed, it "clearly declines" to do so. *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995).

Because EMTALA does not impose a standard of care, it does not require any specific medical procedure (other than the requirement of delivery for active labor). Instead, it demands that hospitals treat all patients on the same footing, prohibiting "disparate" treatment, *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), by imposing a legal duty "to provide emergency care to all," *Hardy v. N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789, 792–93 (2d Cir. 1999). Rather than creating a "national … standard of care," *Torretti v. Main Line Hosps., Inc.*, 580 F.3d 168, 173–74 (3d Cir. 2009), EMTALA creates a cause of action merely "for what amounts to failure to treat" based on the treatments permitted by state law, *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).[1]

That fits with EMTALA's purpose: preventing hospitals from "dumping patients who were unable to pay for care." *Jackson*, 246 F.3d at 1254. And that

[1] *Accord Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142–43 (4th Cir. 1996); *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 268, 272 (6th Cir. 1990) (EMTALA's terms "preclude[ ] resort to a malpractice or other objective standard of care"; hospital need merely "act[ ] in the same manner as it would have for the usual paying patient"); *Nartey v. Franciscan Health Hosp.*, 2 F.4th 1020, 1025 (7th Cir. 2021) (per curiam) ("We therefore join the chorus of circuits that have concluded the EMTALA cannot be used to challenge the quality of medical care") (collecting cases); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) (plaintiffs are entitled "to be treated as other similarly situated patients are treated, within the hospital's capabilities"); *Urban ex rel. Urban v. King*, 43 F.3d 523, 525 (10th Cir. 1994) (EMTALA "is neither a malpractice nor a negligence statute"); *Holcomb v. Monahan*, 30 F.3d 116, 117 & n.2 (11th Cir. 1994) (EMTALA creates no negligence or malpractice claims; indigent patients need merely be treated the same as other patients).

statutory purpose—which has nothing to do with abortion—defeats both impossibility preemption and purposes and objectives preemption.

2. EMTALA's stabilization requirement looks to state law for its content.

The state-law foundation of medical practice also permeates the stabilization requirement on which the administration relies. And it precludes its attempt to read a national standard into the stabilization provision in three ways.

First, EMTALA defines the scope of the stabilization requirement according to state law. It limits treatment to what is "within the staff and facilities *available* at the hospital," 42 U.S.C. § 1395dd(b)(1)(A) (emphasis added), which CMS has long understood to be restricted to what is permitted under state law.

CMS's state operations manual says the "available" limitation means a hospital "must provide stabilizing treatment *within its capability and capacity*." State Operations Manual, App. V, at 48 (emphasis added). And those capabilities are limited not just by a hospital's physical space and "specialized services," but by the "*scope of [its staff's] professional licenses*," *id.* (emphasis added), which states alone set. Thus, this Court held in *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 991 (9th Cir. 2001), that EMTALA did not require a 40-bed rural hospital to offer psychiatric treatment where it had no psychiatrists on staff. In the same manner, EMTALA does not require emergency rooms to provide treatments that are unavailable because state law forbids them. If emergency rooms need not hire psychiatrists, neither must they hire abortion providers.

Second, the enforcement of EMTALA's statutory stabilization requirement hinges on several terms defined by state law. The stabilization duty applies based on conditions likely to occur within a "reasonable medical probability," 42 U.S.C. § 1395dd(e)(3)(A), which is a quintessential state-law standard. *See* Robin Kundis Craig, *When Daubert Gets Erie: Medical Certainty and Medical Expert Testimony in Federal Court*, 77 Denv. U.L. Rev. 69, 70 (1999). And its remedial provisions likewise turn on whether a hospital "negligently violates" its provisions—another state-law standard—or whether relief is available "under the law of the State in which the hospital is located." 42 U.S.C. §§ 1395dd(d)(1)(A)-(B), (2)(A). EMTALA's requirements expressly contemplate and embrace a state-law foundation.

Third, the supplementary statutes that establish the enforcement regime for Medicare—and EMTALA—eschew a national standard in favor of local norms. CMS enforces EMTALA mainly by contracting with quality improvement organizations to conduct surveys of participating hospitals.[2] And by statute, those surveying organizations must apply "*norms of care*, diagnosis, and treatment based upon typical patterns of practice *within the geographic area served by the organization*." 42 U.S.C. § 1320c-3(a)(6) (emphasis added). If those organizations look to "national norms" at all, the statute directs them to "consider" them only "where appropriate," not as a mandate. *Id.* And if EMTALA imposes a national standard of treatment for anything—much less for so

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

controversial an issue as abortion—its directive to do so is found nowhere in its text or in anything else in the Medicare Act.

3. Treating EMTALA as a national abortion mandate leads to nonsensical results.

The administration's extra-textual vision of EMTALA would also impose grave downstream consequences. Under the administration's view, if a person presents with a condition that could result in "serious impairment to bodily functions," 42 U.S.C. § 1395dd(e)(1)(A)(ii), then EMTALA demands the physician prescribe any appropriate treatment, regardless of state law. The physician's judgment would thus override contrary state regulations and make that treatment "available" at the hospital, but it would do so only in the emergency room.

By making doctors a law unto themselves, the administration's view would compel an organ transplant in the ER whenever the physician believed it necessary, regardless of state laws on organ donation. It would even compel organ transplant by a nurse who believed himself capable of the procedure but wasn't duly licensed. And it would authorize doctors to prescribe medical marijuana, opioids, or even a lobotomy in violation of state law. *E.g.*, Idaho Code § 37-2705(d)(29) (THC schedule I controlled substance); *id.* § 39-4514; (prohibition on euthanasia); *id.* § 16-2423(3) (prohibition on pediatric psychosurgery and electroconvulsive treatment).

Plus, despite the United States' disclaimer, *see Moyle*, 144 S. Ct. at 2021 (Barrett, J., concurring), the logic of its position would also mean that EMTALA opens a "mental health" loophole for abortion. It would authorize emergency-room doctors to perform abortions whenever they say those abortions are necessary to avoid

"serious jeopardy" to the mother's mental health. 42 U.S.C. § 1395dd(e)(1)(A)(i). Indeed, the United States has insisted that mental health remains a component of the health that EMTALA requires hospitals to consider in applying its stabilization requirement. Oral Arg. Tr. at 77–78; *Moyle*, 144 S. Ct. at 2039 (Alito, J., dissenting). Perhaps that is why the United States has refused to modify the injunction to conform to its mental health disclaimer.

D. EMTALA's uncontroverted enforcement history forecloses the federal government's radical new gloss.

If EMTALA were unambiguous in demanding that hospitals perform abortions even when prohibited by state law, one would expect that in the many decades since its enactment, it would have been enforced that way. But no such evidence or no such case exists. Not one. To the contrary, during the entire 36 years before the federal government's novel reading of the statute, the federal government never construed EMTALA as mandating abortion.

The United States' own evidence of enforcement shows this. In the Supreme Court, the government proffered spreadsheets of CMS hospital survey records. But of the 115,000 survey summaries, it identified just seven that it says support its abortion mandate. U.S. Br. at 16 n.2 (citing CMS, *Hospital Surveys with 2567 Statement of Deficiencies - 2023Q4* (last modified Feb. 13, 2024), https://perma.cc/8UCY-DK7Y). As the administration acknowledges, five of those instances involved treating ectopic pregnancies, *see id.*, which Idaho law allows. One involved a failure to stabilize a pregnant woman's pain and said nothing about the facility failing to provide an abortion. (2010-2016 file, cited as Row 20,800 in U.S. Br., Row 69,788 in current

spreadsheet.) In the last case, "the hospital was faulted, not for failing to perform an abortion, but for discharging a sick pregnant woman without calling for an ambulance to transport her to another hospital," *Moyle*, 144 S. Ct. at 2032 (Alito, J., dissenting)—actions that "compromise[ed] the health of the unborn baby *and* patient," (2010-2016 File, cited as Row 16,963 in U.S. Br., Row 54,373 in current spreadsheet (emphasis added)). That the only relevant enforcement example expressly identifies a hospital's obligation to the unborn child shows how baseless this newfound EMTALA theory is.

The same goes for the administration's invocation of various HHS rules that refer to EMTALA. U.S. Br. at 16–18 & n.2. HHS's 2008 Rule about conscience protections does not say that EMTALA requires abortions that violate state law; rather, it reinforces the interpretation above by acknowledging that EMTALA obligations are "limited to the capabilities of the particular hospital." Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008). Similarly, the 2019 Rule issued by HHS's civil rights office, "like the 2008 Rule," declined to "go into detail as to how its provisions may or may not interact with other statutes or in all scenarios." Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,183 (May 21, 2019). Even the federal government's 2021 guidance does not use the word "abortion" but merely stated that stabilizing treatment "could" include "dilation and curettage (D&C)," as it would in Idaho for a miscarriage. CMS, *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* 4 (Sept. 17,

2021, revised Oct. 3, 2022). The only rule that ever stated that EMTALA requires abortions was the post-*Dobbs* guidance at issue here.

None of the federal government's cases hold otherwise. *California v. United States* upheld a federal conscience law allowing doctors to refrain from performing abortions, despite the argument that EMTALA required them. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008). *Morin v. Eastern Maine Medical Center* concerned not an abortion but whether to deliver an unborn child that was already dead. 780 F. Supp. 2d 84, 86 (D. Me. 2010). *Ritten v. Lapeer Regional Medical Center* involved a factual dispute about whether a patient "was truly in labor" and required premature delivery. 611 F. Supp. 2d 696, 715 (E.D. Mich. 2009). And *New York v. U.S. Department of Health & Human Services* was not an EMTALA case but a ruling against a Trump administration regulation enforcing federal conscience laws, a regulation the current administration rescinded after *Dobbs*. 414 F. Supp. 3d 475, 537–39 (S.D.N.Y. 2019), *appeal withdrawn by* No. 19-4254, 2022 WL 17974424 (2d Cir. Dec. 8, 2022).

Finally, lacking textual support inside EMTALA, the United States looks beyond it to the Affordable Care Act. It cites a provision of that law about abortion found in subsection (d) that says: "[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including ... EMTALA." 42 U.S.C. § 18023(d) (internal quotation marks omitted). But the administration skips over subsection (c), which contains an express savings clause stating that it is not to be construed to preempt state laws about abortion. 42 U.S.C. § 18023(c)(1).

Subsection (c) manifests Congress's express purpose—the "touchstone" of preemption, *Wyeth*, 555 U.S. at 565—and shows how subsection (d) fits within the overall EMTALA framework. If state law allows abortion as a stabilizing treatment (e.g., in California), a hospital does not violate the ACA's abortion subsidy prohibitions by performing it. This provision simply "reaffirms the duty of participating hospitals to comply with EMTALA, but it does not expand what the text of EMTALA requires." *Moyle*, 144 S. Ct. at 2032 (Alito, J., dissenting).

IV. At minimum, the Court should vacate or narrow the injunction based on the United States' concessions.

The district-court injunction cannot stand in its current form. First, the Court should vacate the injunction because case developments show that the administration faces no irreparable harm. And second, at a minimum, the Court should narrow the injunction to reflect the concessions that the federal government made in the Supreme Court that led that Court to dismiss the writ of certiorari as improvidently granted.

A. The United States has no irreparable harm from Idaho law.

The Court may vacate the injunction because the administration has not shown any irreparable harm from Idaho law. Even if the administration were correct in its interpretation of EMTALA (and it is not), it did not establish any practical conflict between EMTALA and the Defense of Life Act—that is, any particular situation in which it says EMTALA would require an abortion that Idaho law would forbid. The United States proffered declarations from physicians who described various emergency-room situations in which, in their medical judgment, abortion was

appropriate. 3-StateER-319–68. But none of those situations pose a conflict with Idaho law. For instance, several declarations address termination of ectopic pregnancies, 3-StateER-205-207, 209, 325–26, 335–36, which the Defense of Life Act does not prohibit. *See* Idaho Code § 18-604(1)(c); *Idaho*, 83 F.4th at 1137. And every other circumstance those declarations describe involved life-threatening circumstances, such that Idaho law would allow an abortion because the physician determined "in his good faith medical judgment" that it was necessary to "prevent the death" of the mother. Idaho Code § 18-622(2)(a)(i); *Planned Parenthood Great Nw.*, 522 P.3d at 1203.

Even the federal government's example of pre-term, premature rupture of membranes (PPROM)—rupture of the amniotic sac before 37 weeks—shows how its view of EMTALA does not create a practical conflict with what Idaho law permits. 3-StateER-191–92. Under Idaho's Defense of Life Act, a doctor treating a patient with PPROM pre-viability will try to save the lives and preserve the health of both the mother *and* her child. Idaho Code § 18-622(2)(a)(i). By monitoring the mother's temperature and white-blood-cell count, the doctor can watch for infection and prescribe antibiotics if necessary. PPROM Foundation, *PPROM Facts*, (June 21, 2024), https://www.aapprom.org/community/ppromfacts. In 90% of cases, the mother and baby will be fine for the few weeks necessary until viability, when the baby can be delivered safely, honoring the lives of both patients. *See id.* (citing J. Brumbaugh et al., *Neonatal Survival After Prolonged Preterm Premature Rupture of Membranes Before 24 Weeks of Gestation*, 124 Obstetrics & Gynecology 992 (2014)). And in the unlikely and tragic event that the mother's condition destabilizes, Idaho law authorizes the same thing

the administration says is required: to end the pregnancy if necessary to save the mother's life.

This Court should vacate the injunction for lack of irreparable injury.

B. The concessions the administration made in the Supreme Court require narrowing the injunction.

At the very least, the Court should narrow or modify the injunction to reflect the concessions the administration made to the Supreme Court about its position. Three justices would have left the stay in place, *see Moyle*, 144 S. Ct. at 2027 (Alito, J., dissenting), and three others concurred in the dismissal of the writ because of the administration's narrowing concessions, which they said "will not stop Idaho from enforcing its law in the vast majority of circumstances," *Id.* at 2022 (Barrett, J., concurring).

The administration's concessions consisted of positions that it "disclaimed," "emphatically disavowed," "clarified," and "emphasized." *Id.* at 2021 & n.* (Barrett, J., concurring). Those concessions should be given effect—the administration may not prevail "in one phase of a case on an argument and then rely[ ] on a contradictory argument to prevail in another phase," *Pegram v. Herdrich*, 530 U.S. 211, 227 n.8 (2000), "changing positions according to the exigencies of the moment." *New Hampshire v. Maine*, 532 U.S. 742, 750 (2001) (citation omitted).

Yet the concessions that mattered in the Supreme Court have not yet been given effect. Despite Idaho's direct request, the administration has refused to modify the injunction to incorporate these concessions and has opposed Idaho's motion in the district court to do so. Instead, just two business days after the Supreme Court's

order, the administration issued new guidance that "[r]eaffirms" its expansive interpretation of EMTALA, with no mention of its concessions. *See* Becerra Ltr. That has caused considerable confusion regarding the administration's enforcement policy, particularly since the new guidance threatens that a hospital that does not comply with its interpretation would face "termination of its Medicare provider agreement or the imposition of civil monetary penalties." *Id.*

At a minimum, then, this Court should modify the injunction to reflect those concessions by stating that it does not prohibit enforcement of Idaho's Defense of Life Act in the following situations: (1) abortions sought for mental health reasons; (2) abortions to which doctors or hospitals object as a matter of conscience; (3) abortions after 22 weeks; and (4) any abortion sought in a non-acute context.

1. The administration maintained that EMTALA does not require abortions for mental-health reasons.

The administration made critical concessions in the Supreme Court about mental health under EMTALA. It had maintained in this Court that "EMTALA requires whatever treatment a provider concludes is medically necessary to stabilize whatever emergency condition is present." Consolidated Br. of U.S. at 18, ECF No. 35. That broad formulation mattered because HHS's own regulations have long considered an emergency medical condition to include mental health conditions—i.e., "psychiatric disturbances." 42 C.F.R. § 489.24(b); *see also Moyle*, 144 S. Ct. at 2039 (Alito, J., dissenting). But "[a]t the merits stage" in the Supreme Court, the United States "emphatically disavowed the notion that an abortion is ever required as stabilizing treatment for mental health conditions." *Id.* at 2021 (Barrett, J., concurring)

(citation omitted). Three justices found this "an important concession," explaining that this "reading of EMTALA does not gut Idaho's Act." *Id.* As a result, they voted to lift the stay.

That matters because the injunction does not reflect this late-breaking concession. 1-ER-051–52. Nor does the administration's new guidance address this significant change—rather than stating that mental health cannot be a ground for abortion, the administration's new guidance seemingly embraces the same broad reading of "health" that it has advanced since 2022. Becerra Ltr.; *see also* Oral Arg. Tr. at 77–78; *Moyle*, 144 S. Ct. at 2039 (Alito, J., dissenting). And far from acknowledging the "dramatic narrowing" of this dispute, *Moyle*, 144 S. Ct. at 2022 (Barrett, J., concurring), the administration insists that "[f]ederal EMTALA requirements have not changed" from its 2022 guidance. Becerra Ltr. The Court should narrow the injunction to hold the administration to its important mental health concession.

2. The administration acknowledged the conscience protections it opposed before.

The administration also made the significant concession that federal conscience protections supersede EMTALA's requirements both for physicians and for hospitals. Previously, the administration argued in this Court that those conscience protections "do not apply on their own terms" to EMTALA and that instead those laws "reinforce[d]" that abortion was stabilizing treatment. U.S. Br. at 43. As the administration explained then, "EMTALA requires hospitals to offer abortion care when treating physicians deem it necessary." *Id.* at 15 (heading, emphasis removed). It was precisely *because* the administration's 2022 guidance on EMTALA had ignored

those conscience protections that two groups of pro-life physicians challenged it in another lawsuit. *See Texas*, 89 F.4th at 536 & n.5.

But once the Supreme Court granted review, the administration came to acknowledge the conscience protections for hospitals that it had previously denied. "[T]he United States clarified that federal conscience protections, for both hospitals and individual physicians, apply in the EMTALA context." *Moyle*, 144 S. Ct. at 2021 (Barrett, J., concurring). At argument, the Solicitor General assured the Court that EMTALA "does not override" the conscience protections in the Weldon Amendment, Church Amendment, and Coats-Snowe Amendment (and presumably the Hyde Amendment, too). Oral Arg. Tr. at 87–90. In fact, she 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. Three justices found this change in position to be "another critical point" that "alleviates Idaho's concern that the Government's interpretation of EMTALA would strip healthcare providers of conscience protections." *Moyle*, 144 S. Ct. at 2021 (Barrett, J., concurring).

Yet almost as soon as the Solicitor General made this concession, the administration began walking away from it. Immediately after the Court's lifting of the stay, the administration reinstituted its demand that "the provider must offer" abortion where it is needed to treat a patient "experiencing an emergency medical condition as defined by EMTALA." Becerra Ltr. The letter's *only* reference to conscience protections was to acknowledge the Fifth Circuit's rejection of its position in a footnote. *Id.*

All of this matters because the district court's injunction here is silent about conscience protections for doctors and hospitals. 1-ER-051–52. Left in place, that injunction will continue to endorse a view of the law that the administration in its arguments to the Supreme Court agreed was wrong. The Court should modify the injunction to implement what the parties concede is the correct view of the law.

3. The administration conceded that EMTALA requires delivery—not abortion—after viability.

The administration "also clarified that if pregnancy seriously jeopardizes the woman's health postviability, EMTALA requires delivery, not abortion." *Moyle*, 144 S. Ct. at 2021 n.* (Barrett, J., concurring) (citing U.S. Br. at 10; Tr. of Oral Arg. 75). This too was a change from the administration's prior position before this Court, where it clearly articulated its view that the physician chooses "whatever treatment" the physician believes is medically necessary. Consolidated Br. of U.S. at 18. But before the Supreme Court, the administration scrapped that position in part and argued that at least after viability, abortion cannot be stabilizing treatment because EMTALA requires delivery. *Moyle*, 144 S. Ct. at 2021 n.* (Barrett, J., concurring). The injunction knows no such limits—rather, "it is very likely that the preliminary injunction will lead to more abortions, including in at least some cases where the fetus is viable." *Id.* at 2035 (Alito, J., dissenting). This concession is absent from the administration's new guidance, and this Court should modify the injunction to implement it.

4. The administration admitted that any abortion under EMTALA would be limited to acute circumstances.

At oral argument, the administration also drew back on its prior position by acknowledging "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.'" *Moyle*, 144 S. Ct. at 2021 n.* (Barrett, J., concurring) (quoting Tr. of Oral Arg. 79–80). Three justices stated that this "narrow[ed] the scope of EMTALA's potential conflict with Idaho's Act." *Id.*

Indeed, the administration had previously advanced—and obtained an injunction from the district court endorsing—the far more expansive view expressed in its 2022 guidance: 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." Reply Mem. in Supp. of Mot. for Prelim. Inj. at 17, No. 1:22-cv-329 (D. Idaho Aug. 19, 2022), ECF No. 86 (emphasis added); U.S. Consolidated Opp. to Mots. for Reconsideration at 18, No. 1:22-cv-329 (D. Idaho Oct. 12, 2022), ECF No. 106. That injunction permits abortions as stabilizing care not only where necessary to avoid material deterioration of an emergency medical condition, 42 U.S.C. § 1395dd(e)(3)(A), but also where necessary to *prevent* an emergency medical condition in the first place. 1-ER-051–52. And while EMTALA defines an emergency medical condition as one with "acute symptoms" requiring "immediate medical attention," 42 U.S.C. § 1395dd(e)(1)(A), the district court's injunction directed to avoiding emergency medical conditions contains no such limitations, 1-ER-051–52. The lower court's reading of EMTALA greatly

expands the scope of the statute, so much so that the administration did not even dispute Idaho's contention in the Supreme Court that the injunction was overbroad in this respect. Yet the administration has declined to modify the injunction. This Court should do so.

CONCLUSION

The Court should vacate the district court's injunction or, at minimum, narrow it consistent with the administration's concessions.

Respectfully submitted,

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By: */s/ Alan M. Hurst*

RAUL R. LABRADOR
ATTORNEY GENERAL

ALAN M. HURST
SOLICITOR GENERAL
MICHAEL A. ZARIAN
700 W Jefferson St #210
Boise, ID 83720
(208) 332-3548
alan.hurst@ag.idaho.gov
michael.zarian@ag.idaho.gov

JAMES A. CAMPBELL
JOHN J. BURSCH
ERIN M. HAWLEY
LINCOLN DAVIS WILSON
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001
(202) 393-8690
jcampbell@ADFlegal.org
jbursch@ADFlegal.org
ehawley@ADFlegal.org
lwilson@ADFlegal.org

Counsel for Appellant the State of Idaho

STATEMENT OF RELATED CASES

The State of Idaho is unaware of any related cases currently pending in this Court.

/s/ Alan M. Hurst
Alan M. Hurst
Attorney for Appellant State of Idaho

September 13, 2024

CERTIFICATE OF SERVICE

I hereby certify that on September 13, 2024 I electronically filed the foregoing Opening Brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system, which will accomplish service on counsel for all parties through the Court's electronic filing system.

/s/ Alan M. Hurst
Alan M. Hurst
Attorney for Appellant State of Idaho

September 13, 2024

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 23-35440, 23-35450

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APPEAL NOS. 23-35440, 23-35450

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

STATE OF IDAHO,

Defendant-Appellant,

v.

MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE,

Movants-Appellants.

On Appeal from the United States District Court
for the District of Idaho
Case No. 1:22-cv-00329-BLW

ADDENDUM TO REPLACEMENT OPENING BRIEF OF APPELLANT STATE OF IDAHO

JAMES A. CAMPBELL
JOHN J. BURSCH
ERIN M. HAWLEY
LINCOLN DAVIS WILSON
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001
(202) 393-8690
jcampbell@ADFlegal.org
jbursch@ADFlegal.org
ehawley@ADFlegal.org
lwilson@ADFlegal.org

RAUL R. LABRADOR
ATTORNEY GENERAL
ALAN M. HURST
SOLICITOR GENERAL
MICHAEL A. ZARIAN
700 W Jefferson St #210
Boise, ID 83720
(208) 332-3548
alan.hurst@ag.idaho.gov
michael.zarian@ag.idaho.gov

Counsel for Appellant State of Idaho

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KeyCite Yellow Flag - Negative Treatment
Unconstitutional or Preempted Negative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)

42 U.S.C.A. § 1395

§ 1395. Prohibition against any Federal interference

Currentness

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1801, as added Pub.L. 89-97, Title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Notes of Decisions (67)

42 U.S.C.A. § 1395, 42 USCA § 1395
Current through P.L.118-10. Some statute sections may be more current, see credits for details.

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United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part E. Miscellaneous Provisions (Refs & Annos)

42 U.S.C.A. § 1395dd

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

Effective: December 27, 2020
Currentness

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

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A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer--

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who--

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

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(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

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(e) Definitions

In this section:

(1) The term "emergency medical condition" means--

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

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(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1867, as added Pub.L. 99-272, Title IX, § 9121(b), Apr. 7, 1986, 100 Stat. 164; amended Pub.L. 99-509, Title IX, § 9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub.L. 99-514, Title XVIII, § 1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub.L. 100-203, Title IV, § 4009(a)(1), formerly § 4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330-56, 1330-57; renumbered and amended Pub.L. 100-360, Title IV, § 411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub.L. 100-485, Title VI, § 608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub.L. 101-239, Title VI, §§ 6003(g)(3)(D)(xiv), 6211(a) to (h), Dec. 19, 1989, 103 Stat. 2154, 2245; Pub.L. 101-508, Title IV, §§ 4008(b)(1) to (3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388-44, 1388-117, 1388-124; renumbered and amended Pub.L. 103-432, Title I, § 160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub.L. 105-33, Title IV, § 4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub.L. 108-173, Title VII, § 736(a)(14), Title IX, § 944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423; Pub.L. 112-40, Title II, § 261(a)(3)(A), (E), Oct. 21, 2011, 125 Stat. 423; Pub.L. 116-260, Div. CC, Title I, § 125(b)(2)(B), Dec. 27, 2020, 134 Stat. 2966.)

EXECUTIVE ORDERS

EXECUTIVE ORDER NO. 13952

<September 25, 2020, 85 F.R. 62187>

Protecting Vulnerable Newborn and Infant Children

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. Every infant born alive, no matter the circumstances of his or her birth, has the same dignity and the same rights as every other individual and is entitled to the same protections under Federal law. Such laws include the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, which guarantees, in hospitals that have an emergency department, each individual's right to an appropriate medical screening examination and to either stabilizing treatment or an appropriate transfer. They also include section 504 of the Rehabilitation Act (Rehab Act), 29 U.S.C. 794, which prohibits discrimination against individuals with disabilities by programs and activities receiving Federal funding. In addition, the Born-Alive Infants Protection Act, 1 U.S.C. 8, makes clear that all infants born alive are individuals for purposes of these and other Federal laws and are therefore afforded the same legal protections as any other person. Together, these laws help protect infants born alive from discrimination in the provision of medical treatment, including infants who require emergency medical treatment, who are premature, or who are born with disabilities. Such infants are entitled to meaningful and non-discriminatory access to medical examination and services, with the consent of a parent or guardian, when they present at hospitals receiving Federal funds.

Despite these laws, some hospitals refuse the required medical screening examination and stabilizing treatment or otherwise do not provide potentially lifesaving medical treatment to extremely premature or disabled infants, even when parents plead for such treatment. Hospitals might refuse to provide treatment to extremely premature infants_born alive before 24 weeks of gestation_because they believe these infants may not survive, may have to live with long-term disabilities, or may have a quality-of-life deemed to be inadequate. Active treatment of extremely premature infants has, however, been shown to improve their survival rates. And the denial of such treatment, or discouragement of parents from seeking such treatment for their children, devalues the lives of these children and may violate Federal law.

Sec. 2. Policy. It is the policy of the United States to recognize the human dignity and inherent worth of every newborn or other infant child, regardless of prematurity or disability, and to ensure for each child due protection under the law.

Sec. 3. (a) The Secretary of Health and Human Services (Secretary) shall ensure that individuals responsible for all programs and activities under his jurisdiction that receive Federal funding are aware of their obligations toward infants, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment, under EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act. In particular, the Secretary shall ensure that individuals responsible for such programs and activities are aware that they are not excused from complying with these obligations, including the obligation to provide an appropriate medical screening examination and stabilizing treatment or transfer, when extremely premature infants are born alive or infants are born with disabilities. The Secretary shall also ensure that individuals responsible for such programs and activities are aware that they may not unlawfully discourage parents from seeking medical treatment for their infant child solely because of their infant child's disability. The Secretary shall further ensure that individuals responsible for such programs and activities are aware of their obligations to provide stabilizing treatment that will allow the infant patients to be transferred to a more suitable facility if appropriate treatment is not possible at the initial location.

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(b) The Secretary shall, as appropriate and consistent with applicable law, ensure that Federal funding disbursed by the Department of Health and Human Services is expended in full compliance with EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act, as reflected in the policy set forth in section 2 of this order.

(i) The Secretary shall, as appropriate and to the fullest extent permitted by law, investigate complaints of violations of applicable Federal laws with respect to infants born alive, including infants who have an emergency medical condition in need of stabilizing treatment or infants with disabilities whose parents seek medical treatment for their infants. The Secretary shall also clarify, in an easily understandable format, the process by which parents and hospital staff may submit such complaints for investigation under applicable Federal laws.

(ii) The Secretary shall take all appropriate enforcement action against individuals and organizations found through investigation to have violated applicable Federal laws, up to and including terminating Federal funding for non-compliant programs and activities.

(c) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding and National Institutes of Health research dollars for programs and activities conducting research to develop treatments that may improve survival_especially survival without impairment_of infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(d) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding to programs and activities, including hospitals, that provide training to medical personnel regarding the provision of life-saving medical treatment to all infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(e) The Secretary shall, as necessary and consistent with applicable law, issue such regulations or guidance as may be necessary to implement this order.

Sec. 4. General Provisions. **(a)** Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP

Notes of Decisions (569)

Footnotes

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

42 U.S.C.A. § 1395dd, 42 USCA § 1395dd
Current through P.L.118-10. Some statute sections may be more current, see credits for details.

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KeyCite Yellow Flag - Negative Treatment
Unconstitutional or Preempted Prior Version Held Unconstitutional by Planned Parenthood of Idaho, Inc. v. Wasden, 9th Cir.(Idaho), July 16, 2004

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

West s Idaho Code Annotated
Title 18. Crimes and Punishments
Chapter 6. Abortion and Contraceptives

I.C. § 18-604

§ 18-604. Definitions

Effective: July 1, 2023
Currentness

As used in this chapter:

(1) "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean:

(a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus;

(b) The removal of a dead unborn child;

(c) The removal of an ectopic or molar pregnancy; or

(d) The treatment of a woman who is no longer pregnant.

(2) "Department" means the Idaho department of health and welfare.

(3) "Down syndrome" means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as "trisomy 21."

(4) "Emancipated" means any minor who has been married or is in active military service.

(5) "Fetus" and "unborn child." Each term means an individual organism of the species Homo sapiens from fertilization until live birth.

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(6) “First trimester of pregnancy” means the first thirteen (13) weeks of a pregnancy.

(7) “Hospital” means an acute care general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(8) “Informed consent” means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption.

The physician must provide the information in terms that can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.

(9) “Medical emergency” means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(10) “Minor” means a woman under eighteen (18) years of age.

(11) “Pregnant” and “pregnancy.” Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(12) “Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(13) “Second trimester of pregnancy” means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18-608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(14) “Third trimester of pregnancy” means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

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(15) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

Credits

Added by S.L. 1973, ch. 197, § 3. Amended by S.L. 2000, ch. 7, § 2; S.L. 2005, ch. 393, § 2; S.L. 2006, ch. 438, § 1, eff. July 1, 2006; S.L. 2021, ch. 258, § 1, eff. July 1, 2021; S.L. 2023, ch. 298, § 1, eff. July 1, 2023.

Notes of Decisions (6)

I.C. § 18-604, ID ST § 18-604

Statutes and Constitution are current with effective legislation through Chapters 1 to 314 of the First Regular Session of the Sixty-Seventh Idaho Legislature, which convened on Monday, January 9, 2023, and adjourned on Thursday, April 6, 2023. Some sections may be more current; see credits for details.

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KeyCite Yellow Flag - Negative Treatment
Unconstitutional or Preempted Validity Called into Doubt by Planned Parenthood Greater Northwest v. Labrador, D.Idaho, July 31, 2023

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

West s Idaho Code Annotated
Title 18. Crimes and Punishments
Chapter 6. Abortion and Contraceptives

I.C. § 18-622

§ 18-622. Defense of life act

Effective: July 1, 2023
Currentness

(1) Except as provided in subsection (2) of this section, every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

(2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section:

(a) The abortion was performed or attempted by a physician as defined in this chapter and:

(i) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and

(ii) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b) The abortion was performed or attempted by a physician as defined in this chapter during the first trimester of pregnancy and:

(i) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported to a law enforcement agency that she is the victim of an act of rape or incest and provided a copy of such report

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to the physician who is to perform the abortion. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws; or

(ii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported to a law enforcement agency or child protective services that she is the victim of an act of rape or incest and a copy of such report has been provided to the physician who is to perform the abortion. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws.

(3) If a report concerning an act of rape or incest is made to a law enforcement agency or child protective services pursuant to subsection (2)(b) of this section, then the person who made the report shall, upon request, be entitled to receive a copy of such report within seventy-two (72) hours of the report being made, provided that the report may be redacted as necessary to avoid interference with an investigation.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

Credits

Added by S.L. 2020, ch. 284, § 1, eff. July 1, 2020. Amended by S.L. 2023, ch. 298, § 2, eff. July 1, 2023.

Editors' Notes

VALIDITY

<For opinions denying requests to block the implementation and enforcement of this section, see Planned Parenthood Great Nw., Hawaii, Alaska, Indiana, Kentucky v. State, Nos. 49615, 49817, & 49899, ___ P.3d ___, 2022 WL 3335696 (Idaho Aug. 12, 2022), and see Planned Parenthood Great Nw., Hawaii, Alaska, Indiana, Kentucky v. State, Nos. 49615, 49817, & 49899, 171 Idaho 374, 522 P.3d 1132 (Jan. 5, 2023). For a memorandum decision and order granting a preliminary injunction enjoining the State of Idaho from enforcing subsecs. (2) and (3) [subsec. (1) as amended] of this section as applied to medical care required by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, see U.S. v. Idaho, 623 F.Supp.3d 1096 (D. Idaho Aug. 24, 2022).>

Notes of Decisions (38)

I.C. § 18-622, ID ST § 18-622
Statutes and Constitution are current with effective legislation through Chapters 1 to 314 of the First Regular Session of the Sixty-Seventh Idaho Legislature, which convened on Monday, January 9, 2023, and adjourned on Thursday, April 6, 2023. Some sections may be more current; see credits for details.

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2021 Idaho Laws Ch. 258 (H.B. 302)

IDAHO 2021 SESSION LAWS

FIRST REGULAR SESSION OF THE 66TH LEGISLATURE

Additions are indicated by **Text**; deletions by
~~Text~~ .
Vetoes are indicated by ~~Text~~ ;
stricken material by ~~**Text**~~ .

Ch. 258
H.B. No. 302

AN ACT RELATING TO ABORTION; AMENDING SECTION 18–604, IDAHO CODE, TO DEFINE A TERM AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 18–608, IDAHO CODE, TO REVISE A PROVISION REGARDING ABORTIONS DEEMED NOT TO BE UNLAWFUL AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 18–609, IDAHO CODE, TO PROVIDE THAT CERTAIN PRINTED MATERIAL REGARDING DOWN SYNDROME BE MADE AVAILABLE TO PHYSICIANS, HOSPITALS, OR OTHER FACILITIES PROVIDING ABORTION AND ABORTION–RELATED SERVICES; AMENDING SECTION 18–613, IDAHO CODE, TO PROVIDE A CORRECT CODE REFERENCE AND TO MAKE TECHNICAL CORRECTIONS; AND AMENDING SECTION 18–617, IDAHO CODE, TO PROVIDE A CORRECT CODE REFERENCE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 18–604, Idaho Code, be, and the same is hereby amended to read as follows:

<< ID ST § 18–604 >>

§ 18–604. Definitions

As used in this act:

(1) “Abortion” means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean the use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization or the implantation of a fertilized ovum within the uterus.

(2) “Department” means the Idaho department of health and welfare.

(3) **“Down syndrome” means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as “trisomy 21.”**

(4) “Emancipated” means any minor who has been married or is in active military service.

(~~4~~ **5**) “Fetus” and “unborn child.” Each term means an individual organism of the species ~~h~~ **H**omo sapiens from fertilization until live birth.

(~~5~~ **6**) “First trimester of pregnancy” means the first thirteen (13) weeks of a pregnancy.

(~~6~~ **7**) “Hospital” means an acute care~~,~~ general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(~~7~~ **8**) “Informed consent” means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption.

The physician must provide the information in terms ~~which~~ **that** can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.
(~~8~~ **9**) “Medical emergency” means a condition ~~which~~ **that**, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(~~9~~ **10**) “Minor” means a woman ~~less than~~ **under** eighteen (18) years of age.

(1~~0~~ **1**) “Pregnant” and “pregnancy.” Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(1~~1~~ **2**) “Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(1~~2~~ **3**) “Second trimester of pregnancy” means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18–608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(1~~3~~ **4**) “Third trimester of pregnancy” means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

(1~~4~~ **5**) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

SECTION 2. That Section 18–608, Idaho Code, be, and the same is hereby amended to read as follows:

<< ID ST § 18–608 >>

§ 18–608. Certain abortions permitted—Conditions and guidelines

The provisions of sections 18–605 and 18–606**, Idaho Code,** shall not apply to and neither this act~~,~~ nor other controlling rule of Idaho law~~,~~ shall be deemed to make unlawful an abortion performed by a physician if:

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(1) When performed upon a woman who is in the first trimester of pregnancy, the same is performed following the attending physician's consultation with the pregnant patient and a determination by the physician that such abortion is appropriate in consideration of such factors as in his medical judgment he deems pertinent, including~~,~~ but not limited to physical, emotional, psychological and/or familial factors, ~~that the child would be born with some physical or mental defect,~~ that the pregnancy resulted from rape, incest or other felonious intercourse, and a legal presumption is hereby created that all illicit intercourse with a girl below the age of sixteen (16) **years** shall be deemed felonious for purposes of this section, the patient's age and any other consideration relevant to her well-being or directly or otherwise bearing on her health and, in addition to medically diagnosable matters, including but not limited to such factors as the potential stigma of unwed motherhood, the imminence of psychological harm or stress upon the mental and physical health of the patient, the potential stress upon all concerned of an unwanted child or a child brought into a family already unable, psychologically or otherwise, to care for it, and/or the opinion of the patient that maternity or additional offspring probably will force upon her a distressful life and future; the emotional or psychological consequences of not allowing the pregnancy to continue, and the aid and assistance available to the pregnant patient if the pregnancy is allowed to continue; provided, in consideration of all such factors, the physician may rely upon the statements of and the positions taken by the pregnant patient, and the physician shall not be deemed to have held himself out as possessing special expertise in such matters nor shall he be held liable, civilly or otherwise, on account of his good faith exercise of his medical judgment, whether or not influenced by any such nonmedical factors. Abortions permitted by this subsection shall only be lawful if and when performed in a hospital or in a physician's regular office or a clinic**,** which office or clinic is properly staffed and equipped for the performance of such procedures and respecting which the responsible physician or physicians have made satisfactory arrangements with one **(1)** or more acute care hospitals within reasonable proximity thereof providing for the prompt availability of hospital care as may be required due to complications or emergencies that might arise.

(2) When performed upon a woman who is in the second trimester of pregnancy, the same is performed in a hospital and is, in the judgment of the attending physician, in the best medical interest of such pregnant woman, considering those factors enumerated in subsection (1) of this section and such other factors as the physician deems pertinent.

(3) When performed upon a woman who is in the third trimester of pregnancy**,** the same is performed in a hospital and, in the judgment of the attending physician, corroborated by a like opinion of a consulting physician concurring therewith, either is necessary for the preservation of the life of such woman or, if not performed, such pregnancy would terminate in birth or delivery of a fetus unable to survive. Third**-**trimester abortions undertaken for preservation of the life of a pregnant patient, as permitted by this subsection, shall, consistent with accepted medical practice and with the well-being and safety of such patient, be performed in a manner consistent with preservation of any reasonable potential for survival of a viable fetus.

SECTION 3. That Section 18–609, Idaho Code, be, and the same is hereby amended to read as follows:

<< ID ST § 18–609 >>

§ 18–609. Physicians and hospitals not to incur civil liability—Consent to abortion—Notice

(1) Any physician may perform an abortion not prohibited by this act and any hospital or other facility described in section 18–608, Idaho Code, may provide facilities for such procedures without, in the absence of negligence, incurring civil liability therefor to any person including, but not limited to, the pregnant patient and the prospective father of the fetus to have been born in the absence of abortion, if informed consent for such abortion has been duly given by the pregnant patient.

(2) In order to provide assistance in assuring that the consent to an abortion is truly informed consent, the director of the department of health and welfare shall publish easily comprehended, nonmisleading and medically accurate printed material to be made available at no expense to physicians, hospitals or other facilities providing abortion and abortion-related services, and which shall contain the following:

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(a) Descriptions of the services available to assist a woman through a pregnancy, at childbirth and while the child is dependent, including adoption services, a comprehensive list of the names, addresses, and telephone numbers of public and private agencies that provide such services and financial aid available;

(b) Descriptions of the physical characteristics of a normal fetus, described at two (2) week intervals, beginning with the fourth week and ending with the twenty-fourth week of development, accompanied by scientifically verified photographs of a fetus during such stages of development. The description shall include information about physiological and anatomical characteristics;

(c) Descriptions of the abortion procedures used in current medical practices at the various stages of growth of the fetus and any reasonable foreseeable complications and risks to the mother, including those related to subsequent childbearing;

(d) A list, compiled by the department of health and welfare, of health care providers, facilities and clinics that offer to perform ultrasounds free of charge and that have contacted the department annually with a request to be included in the list. The list shall be arranged geographically and shall include the name, address, hours of operation, telephone number and e-mail address of each entity;

(e) A statement that the patient has a right to view an ultrasound image and to observe the heartbeat monitoring of her unborn child and that she may obtain an ultrasound free of charge. The statement shall indicate that printed materials required by the provisions of this section contain a list, compiled by the department of health and welfare, of health care providers, facilities and clinics that offer to perform such ultrasounds free of charge; ~~and~~

(f) Information directing the patient where to obtain further information and assistance in locating a health care provider whom she can consult about chemical abortion, including the interventions, if any, that may affect the effectiveness or reversal of a chemical abortion, and informs the patient that if she wants to consult with such health care providers, she should contact those health care providers before she takes the abortifacient**; and**

(g) A section specific to unborn children diagnosed with Down syndrome in order to help educate mothers about the development of children with Down syndrome and the resources available in both the private and public sectors to assist parents of children with Down syndrome with the delivery and care of a child born with Down syndrome. The section shall include:

(i) Easily comprehended, medically accurate information regarding the development of a child with Down syndrome, including treatment and therapy strategies available during a pregnancy and after birth; and

(ii) Descriptions of the services available to assist Idaho families with children born with Down syndrome, including adoption services, support agencies, and organizations in both the public and private sectors. Such directory shall include the name, address, telephone number, website, and email address of agencies, ministries, and organizations that provide financial, medical, emotional, and spiritual support services to mothers and families with a child with Down syndrome.

The department shall ensure that a Spanish language version of the informed consent materials required in this subsection is made available to women considering an abortion.

(3)(a) The department of health and welfare shall develop and maintain a stable internet website, that may be part of an existing website, to provide the information described in subsection (2) of this section. No information regarding persons using the website shall be collected or maintained. The department of health and welfare shall monitor the website on a weekly basis to prevent and correct tampering.

(b) As used in this section, "stable internet website" means a website that, to the extent reasonably practicable, is safeguarded from having its content altered other than by the department of health and welfare.

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(c) When a pregnant patient contacts a physician by telephone or visit and inquires about obtaining an abortion, the physician or the physician's agent before or while scheduling an abortion-related appointment must provide the woman with the address of the state-sponsored internet website on which the printed materials described in subsection (2) of this section may be viewed as required in subsection (2) of this section.

(4) Except in the case of a medical emergency, no abortion shall be performed unless, prior to the abortion, the attending physician or the attending physician's agent certifies in writing that the materials provided by the director have been provided to the pregnant patient at least twenty-four (24) hours before the performance of the abortion. If the materials are not available from the director of the department of health and welfare, no certification shall be required. The attending physician, or the attending physician's agent, shall provide any other information required under this act.

(5) Except in the case of medical emergency, no abortion shall be performed unless, prior to an initial consultation or any testing, and not less than twenty-four (24) hours prior to the performance of the abortion, the woman is informed by telephone or in person, by the physician who is to perform the abortion or by an agent of the physician, that ultrasound imaging and heartbeat monitoring are available to the woman enabling the pregnant woman to view her unborn child or observe the heartbeat of the unborn child. The physician or agent of the physician shall inform the pregnant woman that the website and printed materials described in subsection (2)(d), (e) and (f) of this section contain telephone numbers, addresses and e-mail addresses of facilities that offer such services at no cost. If the woman contacts the abortion facility by e-mail, the physician or agent of the physician shall inform the woman of the requirements of this subsection by e-mail with the required information in a larger font than the rest of the e-mail. No fee for an abortion shall be collected prior to providing the information required in this subsection.

(6) All physicians or their agents who use ultrasound equipment in the performance of an abortion shall inform the patient that she has the right to view the ultrasound image of her unborn child before an abortion is performed. If the patient requests to view the ultrasound image, she shall be allowed to view it before an abortion is performed. The physician or agent shall also offer to provide the patient with a physical picture of the ultrasound image of her unborn child prior to the performance of the abortion, and shall provide it if requested by the patient. In addition to providing the material, the attending physician may provide the pregnant patient with such other information which in the attending physician's judgment is relevant to the pregnant patient's decision as to whether to have the abortion or carry the pregnancy to term.

(7) Within thirty (30) days after performing any abortion without certification and delivery of the materials, the attending physician, or the attending physician's agent, shall cause to be delivered to the director of the department of health and welfare, a report signed by the attending physician, preserving the patient's anonymity, denoting the medical emergency that excused compliance with the duty to deliver the materials. The director of the department of health and welfare shall compile the information annually and report to the public the total number of abortions performed in the state where delivery of the materials was excused; provided that any information so reported shall not identify any physician or patient in any manner which would reveal their identities.

(8) If section 18–608(3), Idaho Code, applies to the abortion to be performed and the pregnant patient is an adult and for any reason unable to give a valid consent thereto, the requirement for that pregnant patient's consent shall be met as required by law for other medical or surgical procedures and shall be determined in consideration of the desires, interests and welfare of the pregnant patient.

(9) The knowing failure of the attending physician to perform any one (1) or more of the acts required under subsection (7) of this section or section 39–261, Idaho Code, is grounds for discipline pursuant to section 54–1814(6), Idaho Code, and shall subject the physician to assessment of a civil penalty of one hundred dollars ($100) for each month or portion thereof that each such failure continues, payable to the vital statistics unit of the department of health and welfare, but such failure shall not constitute a criminal act.

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SECTION 4. That Section 18–613, Idaho Code, be, and the same is hereby amended to read as follows:

<< ID ST § 18–613 >>

§ 18–613. Partial-birth abortions prohibited

(1) Prohibited acts. Any physician who knowingly performs a partial-birth abortion and thereby kills a human fetus shall be subject to the penalties imposed in section 18–605, Idaho Code. This section shall not apply to partial-birth abortions necessary to save the life of the mother when her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(2) Definitions. As used in this section:

(a) "Fetus" has the same meaning as provided in section 18–604(4 **5**), Idaho Code.

(b) "Partial-birth abortion" means an abortion in which the person performing the abortion:

(i) Deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the physician knows will kill the partially delivered living fetus; and

(ii) Performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

(c) "Physician" has the same meaning provided in section 18–604, Idaho Code. However, any individual who is not a physician or not otherwise legally authorized by this state to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions described in this section.

(3)(a) Civil actions. The father of the aborted fetus, if married to the mother of the aborted fetus at the time of the partial-birth abortion; **,** or the maternal grandparents of the aborted fetus, if the mother is not at least eighteen (18) years of age at the time of the abortion, may bring a civil action against the defendant physician to obtain appropriate relief. Provided however, that a civil action by the father is barred if the pregnancy resulted from the father's criminal conduct or **if** the father consented to the abortion. Further, a civil action by the maternal grandparents is barred if the pregnancy is the result of a maternal grandparent's criminal conduct or **if** a maternal grandparent consented to the abortion.

(b) As used in this section, "appropriate relief" shall include:

(i) Money damages for all mental and physical injuries suffered by the plaintiff as a result of the abortion performed in violation of this section;

(ii) Money damages equal to three (3) times the cost of performing the abortion procedure.

(4)(a) Hearing. A physician accused of violating this section may request a hearing before the state board of medicine on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(b) The findings of the board of medicine regarding the issues described in paragraph (a) of this subsection are admissible at the criminal and civil trials of the defendant physician. Upon a motion by the defendant physician, the court shall delay the beginning of the criminal and civil trials for not more than thirty (30) days to permit the hearing to take place.

(5) Immunity. A woman upon whom a partial-birth abortion is performed shall not be prosecuted for violations of this section, for conspiracy to violate this section, or for violations of section 18–603, 18–605 or 18–606, Idaho Code, in regard to the partial-birth abortion performed.

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SECTION 5. That Section 18–617, Idaho Code, be, and the same is hereby amended to read as follows:

<< ID ST § 18–617 >>

§ 18–617. Chemical abortions

(1) As used in this section:

(a) “Abortifacient” means mifepristone, misoprostol and/or other chemical or drug dispensed with the intent of causing an abortion as defined in section 18–604(1), Idaho Code. Nothing in the definition shall apply when used to treat ectopic pregnancy;

(b) “Chemical abortion” means the exclusive use of an abortifacient or combination of abortifacients to effect an abortion;

(c) “Physician” has the same meaning as provided in section 18–604(1~~1~~ **2**), Idaho Code.

(2) No physician shall give, sell, dispense, administer, prescribe or otherwise provide an abortifacient for the purpose of effecting a chemical abortion unless the physician:

(a) Has the ability to assess the duration of the pregnancy accurately in accordance with the applicable standard of care for medical practice in the state;

(b) Has determined, if clinically feasible, that the unborn child to be aborted is within the uterus and not ectopic;

(c) Has the ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or, if the physician does not have admitting privileges at a local hospital, has made and documented in the patient's medical record plans to provide such emergency care through other qualified physicians who have agreed in writing to provide such care;

(d) Informs the patient that she may need access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary, as a result of or in connection with the abortion procedure on a twenty-four (24) hour basis. If the appropriate medical facility is other than a local hospital emergency room, the physician shall provide the patient with the name, address and telephone number of such facility in writing; and

(e) Has complied with the informed consent provisions of section 18–609, Idaho Code.

(3) The physician inducing the abortion, or a person acting on behalf of the physician inducing the abortion, shall make reasonable efforts to ensure that the patient returns for a follow-up visit so that a physician can confirm that the pregnancy has been terminated and assess the patient's medical condition.

Approved April 20, 2021.
Effective: July 1, 2021.

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2020 Idaho Laws Ch. 284 (S.B. 1385)

IDAHO 2020 SESSION LAWS

SECOND REGULAR SESSION OF THE 65TH LEGISLATURE

Additions are indicated by **Text**; deletions by
~~Text~~ .
Vetoes are indicated by ~~Text~~ ;
stricken material by ~~**Text**~~ .

Ch. 284
S.B. No. 1385

AN ACT RELATING TO ABORTION; AMENDING CHAPTER 6, TITLE 18, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 18–622, IDAHO CODE, TO PROVIDE AN EFFECTIVE DATE, TO PROVIDE FOR THE OFFENSE OF CRIMINAL ABORTION, TO PROVIDE PENALTIES, TO PROVIDE AFFIRMATIVE DEFENSES, AND TO PROVIDE EXCEPTIONS; AND PROVIDING SEVERABILITY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 6, Title 18, Idaho Code, be, and the same is hereby amended by the addition thereto of a **NEW SECTION**, to be known and designated as Section 18–622, Idaho Code, and to read as follows:

<< ID ST § 18–622 >>

§ 18–622. Criminal abortion

(1) Notwithstanding any other provision of law, this section shall become effective thirty (30) days following the occurrence of either of the following circumstances:

(a) The issuance of the judgment in any decision of the United States supreme court that restores to the states their authority to prohibit abortion; or

(b) Adoption of an amendment to the United States constitution that restores to the states their authority to prohibit abortion.

(2) Every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than (5) years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

(3) It shall be an affirmative defense to prosecution under subsection (2) of this section and to any disciplinary action by an applicable licensing authority, which must be proven by a preponderance of the evidence, that:

(a)(i) The abortion was performed or attempted by a physician as defined in this chapter;

(ii) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and

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(iii) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b)(i) The abortion was performed or attempted by a physician as defined in this chapter;

(ii) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported the act of rape or incest to a law enforcement agency and provided a copy of such report to the physician who is to perform the abortion;

(iii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported the act of rape or incest to a law enforcement agency or child protective services and a copy of such report has been provided to the physician who is to perform the abortion; and

(iv) The physician who performed the abortion complied with the requirements of paragraph (a)(iii) of this subsection regarding the method of abortion.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

SECTION 2. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

Approved March 24, 2020.
Effective: July 1, 2020.

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LEGISLATURE OF THE STATE OF IDAHO

Sixty-seventh Legislature First Regular Session - 2023

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 374

BY STATE AFFAIRS COMMITTEE

AN ACT

RELATING TO ABORTION; AMENDING SECTION 18-604, IDAHO CODE, TO REVISE A DEFINITION AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 18-622, IDAHO CODE, TO REVISE THE SECTION CAPTION, TO REMOVE OBSOLETE LANGUAGE, TO PROVIDE THAT CERTAIN ABORTIONS AND ATTEMPTS ARE NOT CRIMINAL ABORTIONS, TO PROVIDE THAT CERTAIN PERSONS SHALL BE ENTITLED TO RECEIVE A CERTAIN REPORT UPON REQUEST AND TO MAKE A TECHNICAL CORRECTION; PROVIDING APPLICABILITY; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 18-604, Idaho Code, be, and the same is hereby amended to read as follows:

18-604. DEFINITIONS. As used in this ~~act~~ chapter:

(1) "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean ~~the~~:

(a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus;

(b) The removal of a dead unborn child;

(c) The removal of an ectopic or molar pregnancy; or

(d) The treatment of a woman who is no longer pregnant.

(2) "Department" means the Idaho department of health and welfare.

(3) "Down syndrome" means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as "trisomy 21."

(4) "Emancipated" means any minor who has been married or is in active military service.

(5) "Fetus" and "unborn child." Each term means an individual organism of the species Homo sapiens from fertilization until live birth.

(6) "First trimester of pregnancy" means the first thirteen (13) weeks of a pregnancy.

(7) "Hospital" means an acute care general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(8) "Informed consent" means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption.

The physician must provide the information in terms that can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.

(9) "Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(10) "Minor" means a woman under eighteen (18) years of age.

(11) "Pregnant" and "pregnancy." Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(12) "Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(13) "Second trimester of pregnancy" means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18-608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(14) "Third trimester of pregnancy" means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

(15) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

SECTION 2. That Section 18-622, Idaho Code, be, and the same is hereby amended to read as follows:

18-622. ~~CRIMINAL ABORTION~~ DEFENSE OF LIFE ACT. ~~(1) Notwithstanding any other provision of law, this section shall become effective thirty (30) days following the occurrence of either of the following circumstances:~~

~~(a) The issuance of the judgment in any decision of the United States supreme court that restores to the states their authority to prohibit abortion; or~~

~~(b) Adoption of an amendment to the United States constitution that restores to the states their authority to prohibit abortion.~~

~~(2) Every~~ (1) Except as provided in subsection (2) of this section, every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison. The professional license of any

health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

~~(3) It shall be an affirmative defense to prosecution under subsection (2) of this section and to any disciplinary action by an applicable licensing authority, which must be proven by a preponderance of the evidence, that:~~

(2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section:

(a) ~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ and:

~~(ii)~~ (i) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and

~~(iii)~~ (ii) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b) ~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ during the first trimester of pregnancy and:

~~(ii)~~ (i) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported ~~the act of rape or incest~~ to a law enforcement agency that she is the victim of an act of rape or incest and provided a copy of such report to the physician who is to perform the abortion~~;~~. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws; or

~~(iii)~~ (ii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported ~~the act of rape or incest~~ to a law enforcement agency or child protective services that she is the victim of an act of rape or incest and a copy of such report has been provided to the physician who is to perform the abortion~~; and~~. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws.

~~(iv) The physician who performed the abortion complied with the requirements of paragraph (a)(iii) of this subsection regarding the method of abortion.~~

(3) If a report concerning an act of rape or incest is made to a law enforcement agency or child protective services pursuant to subsection (2)(b) of this section, then the person who made the report shall, upon request, be

1 entitled to receive a copy of such report within seventy-two (72) hours of
2 the report being made, provided that the report may be redacted as necessary
3 to avoid interference with an investigation.
4 (4) Medical treatment provided to a pregnant woman by a health care pro-
5 fessional as defined in this chapter that results in the accidental death of,
6 or unintentional injury to, the unborn child shall not be a violation of this
7 section.
8 (5) Nothing in this section shall be construed to subject a pregnant
9 woman on whom any abortion is performed or attempted to any criminal convic-
10 tion and penalty.

11 SECTION 3. Section 2 of this act shall apply retroactively to any pend-
12 ing claim or defense, whether or not asserted, as of July 1, 2023.

13 SECTION 4. An emergency existing therefor, which emergency is hereby
14 declared to exist, this act shall be in full force and effect on and after
15 July 1, 2023.

STATEMENT OF PURPOSE

RS30769C1 / H0374

This legislation amends Idaho Code, Section 18-622 to clarify our existing definition of abortion and it eliminates the trigger provision and affirmative defense. The legislation also provides additional clarifying language regarding the reporting standard on rape and incest.

FISCAL NOTE

This legislation causes no additional expenditure of funds at the state or local level of government, nor does it cause an increase or decrease in revenue for state or local government. Therefore, the legislation has no fiscal impact.

Contact:
Representative Megan Blanksma
Senator Todd Lakey
(208) 332-1000

DISCLAIMER: This statement of purpose and fiscal note are a mere attachment to this bill and prepared by a proponent of the bill. It is neither intended as an expression of legislative intent nor intended for any use outside of the legislative process, including judicial review (Joint Rule 18).

LEGISLATURE OF THE STATE OF IDAHO

Sixty-fifth Legislature Second Regular Session - 2020

IN THE SENATE

SENATE BILL NO. 1385

BY STATE AFFAIRS COMMITTEE

1 AN ACT
2 RELATING TO ABORTION; AMENDING CHAPTER 6, TITLE 18, IDAHO CODE, BY THE ADDI-
3 TION OF A NEW SECTION 18-622, IDAHO CODE, TO PROVIDE AN EFFECTIVE DATE,
4 TO PROVIDE FOR THE OFFENSE OF CRIMINAL ABORTION, TO PROVIDE PENALTIES,
5 TO PROVIDE AFFIRMATIVE DEFENSES, AND TO PROVIDE EXCEPTIONS; AND PROVID-
6 ING SEVERABILITY.

7 Be It Enacted by the Legislature of the State of Idaho:

8 SECTION 1. That Chapter 6, Title 18, Idaho Code, be, and the same is
9 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
10 ignated as Section 18-622, Idaho Code, and to read as follows:

11 18-622. CRIMINAL ABORTION. (1) Notwithstanding any other provision of
12 law, this section shall become effective thirty (30) days following the oc-
13 currence of either of the following circumstances:
14 (a) The issuance of the judgment in any decision of the United States
15 supreme court that restores to the states their authority to prohibit
16 abortion; or
17 (b) Adoption of an amendment to the United States constitution that re-
18 stores to the states their authority to prohibit abortion.
19 (2) Every person who performs or attempts to perform an abortion as de-
20 fined in this chapter commits the crime of criminal abortion. Criminal abor-
21 tion shall be a felony punishable by a sentence of imprisonment of no less
22 than two (2) years and no more than (5) years in prison. The professional li-
23 cense of any health care professional who performs or attempts to perform an
24 abortion or who assists in performing or attempting to perform an abortion in
25 violation of this subsection shall be suspended by the appropriate licensing
26 board for a minimum of six (6) months upon a first offense and shall be perma-
27 nently revoked upon a subsequent offense.
28 (3) It shall be an affirmative defense to prosecution under subsection
29 (2) of this section and to any disciplinary action by an applicable licensing
30 authority, which must be proven by a preponderance of the evidence, that:
31 (a)(i) The abortion was performed or attempted by a physician as
32 defined in this chapter;
33 (ii) The physician determined, in his good faith medical judgment
34 and based on the facts known to the physician at the time, that the
35 abortion was necessary to prevent the death of the pregnant woman.
36 No abortion shall be deemed necessary to prevent the death of the
37 pregnant woman because the physician believes that the woman may
38 or will take action to harm herself; and
39 (iii) The physician performed or attempted to perform the abortion
40 in the manner that, in his good faith medical judgment and based
41 on the facts known to the physician at the time, provided the best
42 opportunity for the unborn child to survive, unless, in his good

faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b)(i) The abortion was performed or attempted by a physician as defined in this chapter;

(ii) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported the act of rape or incest to a law enforcement agency and provided a copy of such report to the physician who is to perform the abortion;

(iii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported the act of rape or incest to a law enforcement agency or child protective services and a copy of such report has been provided to the physician who is to perform the abortion; and

(iv) The physician who performed the abortion complied with the requirements of paragraph (a)(iii) of this subsection regarding the method of abortion.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

SECTION 2. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

STATEMENT OF PURPOSE

RS27868 / S1385

This bill becomes effective when the United States Supreme Court restores to the states their authority to prohibit abortion, or the United States Constitution is amended to restore to the states their authority to prohibit abortion. Upon the occurrence of these prerequisites, this statute makes the performance of an abortion a crime. It provides affirmative defenses in the cases where the life of the mother is an issue and cases of rape and incest.

FISCAL NOTE

There is no fiscal impact to the state or general fund because this law becomes effective upon future action by the US Supreme Court or an amendment to the United States Constitution. Any future costs resulting from prosecution are dependent upon someone violating the law.

Contact:
Senator Todd M. Lakey
(208) 332-1000
Representative Megan Blanksma
(208) 332-1054

DISCLAIMER: This statement of purpose and fiscal note are a mere attachment to this bill and prepared by a proponent of the bill. It is neither intended as an expression of legislative intent nor intended for any use outside of the legislative process, including judicial review (Joint Rule 18).