No. 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, ET AL.
Movants-Appellants.

On Appeal from the United States District Court
for the District of Idaho

No. 1:22-cv-00329-BLW
The Honorable B. Lynn Winmill

REPLY BRIEF OF APPELLANT

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After the Supreme Court held that the Constitution does not include an abortion guarantee, the United States attempted to repurpose EMTALA to include one. But the United States' theory is as meritless as it is novel. EMTALA is an anti-dumping statute that ensures emergency rooms do not withhold treatments from indigent patients. It does not set national standards for treatments every emergency room must offer. And it does not displace states' traditional role as the regulating authority over the practice of medicine.

Idaho has determined that the practice of medicine within its borders will not include most abortions. That is its right. And Congress made clear in EMTALA that states would retain their primacy in regulating the practice of medicine. That is incompatible with the United States' notion that Congress silently planted an abortion guarantee in EMTALA over 30 years ago, only for it to come alive when the Supreme Court returned abortion regulations back to state authority.

Looking just at EMTALA's text, the United States is playing a losing hand. But it gets much worse for the United States when preemption principles are factored in. They impose a heavy burden on the United States, and as this Court recently held, "there is no preemption" here. *United States v. Idaho*, ___F.4th___, 2023 WL 6308107, at *1 (9th Cir. Sept. 28, 2023). The district court's injunction should be dissolved, and the case should be reversed and remanded.

I. The United States Is Not Likely To Succeed On The Merits.

The United States' case as to the entire preliminary injunction analysis turns on its ability to show a likelihood of success on its claims that EMTALA preempts Idaho's abortion laws. But those claims are meritless.

The State of Idaho already called the United States' end game: it is trying to use EMTALA as a bludgeon against states exercising traditional police powers. It does so through the manipulation of a Medicare law intended to prevent patient dumping. And its true aim is to circumvent the Supreme Court's decision in *Dobbs*. *See* Dkt. #12-1 at 26. But its strained efforts to manipulate EMTALA's stabilization requirement to silently displace traditional police powers lack any legal basis and have been all-but rejected by this Court. *See Idaho*, 2023 WL 6308107, at *1. Under any reasonable understanding, there is no direct conflict between Idaho law and EMTALA. It is not physically impossible to comply with both laws; nor is Idaho law an obstacle to EMTALA's purposes.

A. The United States has not shown it is impossible to comply with EMTALA and Idaho law, and in fact, it is not.

The United States' entire case boils down to a simple but seriously wrong premise: EMTALA requires every participating emergency department in the country to provide abortions as "stabilizing treatment"—regardless of a hospital's capabilities or any state law to the contrary. Nothing in EMTALA requires abortions, just as nothing in EMTALA requires emergency departments to provide clival chordoma resection

surgeries, pediatric and prenatal cardiovascular surgeries, lifesaving burn therapies, or any number of other "specific methods of treatment." *Id.* at *3. EMTALA demands equality of treatments offered. It does not force emergency rooms to calibrate their offerings to whatever roster of treatments the current administration deems necessary.

The United States thinks it can impose its abortion regime on states via the impossibility preemption doctrine. But impossibility preemption is not so easily invoked. It "is a demanding defense," *Wyeth v. Levine*, 555 U.S. 555, 573 (2009), especially when, as here, it targets the historic police powers of states. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Because Idaho's sovereign right to regulate the practice of medicine and the health of safety of its people is at stake, this Court must "start with the assumption" that EMTALA does not supersede Idaho law. *Id.* It also means that even if EMTALA has *some* preemptive effect, the Court nevertheless gives EMTALA a particularly "narrow" preemptive *scope*. *Id.* "That approach is consistent with both federalism concerns and the historic primacy of state regulation of matters of health and safety." *Id.*

The United States ignores these basic preemption principles and instead attempts to defend the district court's errant injunction by technicality—mistakenly applied, no less.[1] Over and over, the United States declares arguments "forfeited" and then

[1] A common refrain from the United States is that the State of Idaho has forfeited certain arguments on appeal. *See, e.g.,* Dkt. #35 at 49, 53, 56, 59, 64, 73. Not so. The

proceeds to argue the irrelevant point that an emergency room physician may believe an abortion would provide stabilizing treatment under certain circumstances. But the preemption question on appeal is whether EMTALA *requires* emergency departments to provide abortions that Idaho law forbids. And the answer to that question is an easy "no."

1. *EMTALA does not require emergency departments to offer specific treatments, contrary to the United States' transformation of EMTALA into a federal overhauler of medicine.*

Congress did not pass EMTALA to displace states' traditional role in regulating the practice of medicine. "The purpose of EMTALA is not to impose specific standards of care—such as requiring the provision of abortion—but simply to 'ensure that hospitals do not refuse essential emergency care because of a patient's inability to pay.'" *Idaho*, 2023 WL 6308107, at *3. Twice Congress expressed its clear intent that EMTALA

State has consistently argued that there is no conflict between EMTALA and Idaho Code § 18-622. *See, e.g.,* 3-ER-225, 3-ER-233-41, 3-ER-136, 2-ER-84:18-23, 2-ER-104:23-105:3. The State is not confined to only the specific *reasons* that argument is true that were offered below. "As the Supreme Court has made clear, it is claims that are deemed waived or forfeited, not arguments." *United States v. Pallares-Galan*, 359 F.3d 1088, 1095 (9th Cir. 2004) (citing *Lebron v. Nat'l R.R. Passenger Corp.*, 513 U.S. 374 (1995)); *see also id.* (discussing *Yee v. City of Escondido*, 503 U.S. 519, 535 (1992)); *see also e.g., United States v. Vasquez*, 2023 WL 2985129 at *1, n.1 (9th Cir. 2023) (citing *Pallares-Galan*, 359 F.3d at 1095). And since this entire appeal focuses on legal issues for which this Court can consider, any particular issue that was not raised below may be considered now because it is "purely one of law." *See Flemming v. Matteson*, 26 F.4th 1136, 1144 (9th Cir. 2022)(citing *Bolker v. Comm'r*, 760 F.2d 1039, 1042 (9th Cir. 1985)).

"prohibits" what the United States tries here: "[federal] government action which interferes with the practice of medicine." *See Am. Med. Ass'n v. Weinberger*, 522 F.2d 921, 925 n.6 (7th Cir. 1975). In 42 U.S.C. § 1395, Congress provided that "[n]othing 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."[2] And in 42 U.S.C. § 1395dd(f), Congress emphasized that EMTALA's provisions "do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." Notwithstanding these declarations, the United States wants this Court to hold that EMTALA requires hospitals to offer otherwise unavailable treatments—something no court has ever found within EMTALA's limited requirements.

The United States says that "EMTALA requires *whatever* treatment a provider concludes is medically necessary to stabilize whatever emergency condition is present." Dkt. #35 at 31 (emphasis added). That is a radical and reductionistic statement that eliminates states' roles as the regulators of practice of medicine. And it is quickly shown as such. For example, just because a provider concludes that bloodletting, lobotomies,

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[2] The United States wrongly argues the State forfeit its argument regarding § 1395. *See* Dkt. #35 at 53. The State argued "Congress has expressly disclaimed any power to regulate the practice of medical care in the Medicare Act. 42 U.S.C. § 1395. Instead, this is a power exercised by the States. *See* U.S. Const. amend. X." on reconsideration. *E.g.*, 3-ER-160. And for the same reasons explained in footnote 1, the United States' forfeiture contention is also incorrect.

or radium are medically necessary treatments does not mean EMTALA requires them. Or to take more modern examples, just because a provider believes cannabis, ivermectin, or euthanasia are stabilizing treatments likewise does not mean EMTALA requires them. States have long regulated the practice of medicine within their borders, and their regulation includes the power to determine what is and is not appropriate medical care. The long-understood fact in our dual system of governance is that "there is no right to practice medicine which is not subordinate to the police power of the states." *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926). It is absurd for the United States to claim that EMTALA requires "whatever" treatment a provider deems necessary without regard to what state law permits.

When it comes to the practice of medicine, states get to "[c]hoos[e] what treatments are or are not appropriate for a particular condition." *Judge Rotenberg Educ. Ctr., Inc. v. U.S. Food and Drug Admin.*, 3 F.4th 390, 400 (D.C. Cir. 2021) (collecting cases). That determination "is at the heart" of state regulatory authority over the practice of medicine. *Id.* Thus, this Court has upheld "the right of the state to adopt a policy even upon medical matters concerning which there is difference of opinion and dispute." *Tingley v. Ferguson*, 47 F.4th 1055, 1080 (9th Cir. 2022). Idaho's abortion regulations fall squarely within its power to regulate the practice of medicine, and EMTALA does not snatch that regulatory power from Idaho. That is why this Court said in no uncertain terms that EMTALA "certainly doesn't require that a hospital provide

whatever treatment an individual medical professional may desire." *Idaho*, 2023 WL 6308107, at *3.

The United States' novel preemption argument also fails because EMTALA does not require emergency rooms to offer otherwise unavailable treatments. *See Martindale v. Ind. Univ. Health Bloomington, Inc.*, 39 F.4th 416, 424 (7th Cir. 2022) (rejecting claim that if stabilizing treatment was "possible," then EMTALA required emergency department to provide it); *Feighery v. York Hosp.*, 59 F.Supp.2d 96, 102 (D. Me. 1999) ("[T]he Act does not require a covered hospital to provide a uniform minimum level of care to each patient seeking emergency care."). Not all emergency departments have the same capabilities. Some emergency departments may have world-class pediatric surgeons and facilities so that they can offer patients rare, lifesaving treatments. Others may have more modest resources that mean certain treatments are simply unavailable.

The United States dismisses this point and posits a parade of horribles. Dkt. #35 at 50-51. It suggests that "Idaho could restrict life-saving treatment for non-medical reasons, contrary to the canons of medical ethics, and still benefit from Medicare funding for its hospitals." Dkt. #35 at 51. While it is unclear what "canon of medical ethics" the United States is invoking—EMTALA certainly did not codify one—Idaho's abortion regulations protect both pregnant mothers and unborn children. There is nothing unethical about its policy determination, and the United States does not get to second-guess how Idaho regulates the practice of medicine. *See Idaho*, 2023 WL 6308107, at *3 (making similar point regarding state policy around organ transplantation). And the

remaining so-called "absurd consequences" the United States frets over are all addressed by EMTALA's anti-dumping provision. Any treatments offered, must be offered on an equal basis.

The United States also misconstrues abortion's availability in Idaho. Treatments are specific to diagnoses, and abortion is only an available treatment for certain diagnoses. That is not unusual in the field of medical regulation. Consider opioids, which are appropriate treatments for some medical conditions. For others, they are unavailable, and EMTALA does not demand that a state give up its ability to regulate opioid prescriptions simply because a physician in an emergency room deems them stabilizing treatments.

The United States' attempt to distinguish *Baker v. Adventist Health, Inc.*, 260 F.3d 987 (9th Cir. 2001), is thus unavailing. The screening requirement and the stabilization requirement are both EMTALA requirements, and this Court held that forcing a hospital to provide treatment beyond its capability was "not a tenable position under the statute." *Id.* at 993. The United States seems to accept that, because "the treatment at issue was not 'available' at the hospital," EMTALA did not require that the hospital make it available. Dkt. #35 at 52. Abortions for non-life-threatening conditions are just as unavailable in Idaho emergency rooms as the psychiatric treatment in *Baker*.

The United States cannot maintain a consistent position on this front. It elsewhere admits that EMTALA nowhere specifies that emergency departments must provide abortions as a form of stabilizing care. *Id.* at 30-31. And it acknowledges that

EMTALA "treats pregnancy termination the same as all other potential treatments for emergency medical conditions." *Id.* at 31. The State agrees. Under EMTALA, an emergency room is not required to offer abortions as stabilizing treatment in the same way it would not be required to offer psychiatric care, specialized burn units, or fetal surgeries as stabilizing treatment. A hospital need only provide stabilizing treatment "[w]ithin the capabilities of the staff and facilities available." 42 C.F.R. § 489.24(d)(i).

All of this underscores the inappropriateness of preemption here. Preemption principles require close calls to go to state law and in such cases to leave it intact. This is not a close call. States are "independent sovereigns" and responsible for regulating the practice of medicine. *Medtronic*, 518 U.S. at 485. The Supreme Court recently made clear that abortion is no exception. *Dobbs v. Jackson Women's Health Org.*, 142 S.Ct. 2228, 2284 (2022) (returning the "authority" to regulate abortion "to the people and their elected representatives"). And "Congress enacted the EMTALA not to improve the overall standard of medical care, but to ensure that hospitals do not refuse essential emergency care because of a patient's inability to pay." *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995). The United States' position directly conflicts with this Court's understanding of EMTALA's statutory language and legislative history.

2. EMTALA's transfer provision disproves the United States' position.

The United States' view that "EMTALA requires *whatever* treatment a provider concludes is medically necessary to stabilize whatever emergency condition is present" is also at odds with EMTALA's text and structure. Dkt. #35 at 31 (emphasis added).

When a person presents at an emergency department, is screened, and is found to have an emergency medical condition, EMTALA specifies that the hospital can meet its obligation either by providing stabilizing treatment or a "transfer of the individual in accordance with subsection (c)." 42 U.S.C. § 1395dd(b)(1)(A)-(B); *see also James v. Sunrise Hosp.*, 86 F.3d 885, 889 (9th Cir. 1990). EMTALA permits transfers based on an individual's informed consent or upon a physician's certification that "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." 42 U.S.C. § 1395dd(c)(1)(A).

EMTALA thus recognizes that one hospital may not have the resources, capacity, capabilities, or staff to stabilize every medical condition presented. That was the case in *Ramos-Cruz v. Centro Medico del Turabo*, 642 F.3d 17 (1st Cir. 2011). There, the plaintiffs' son arrived at the emergency department "with a history of abdominal problems and anemia," where he "vomited blood and was diagnosed with upper gastrointestinal bleeding." *Id.* at 18. "Because the Hospital did not have gastroenterologic services available," the treating physician arranged to have the boy transferred. *Id.* The plaintiffs' son died following his transfer, and the plaintiffs sued alleging that the Hospital violated EMTALA. The Court of Appeals held that EMTALA did not require the hospital to have treated the boy's gastrointestinal bleeding and that transfer was appropriate. *Id.* at 19-20.

The Seventh Circuit's recent *Martindale* case confirms the point. There a physician determined "he could not safely operate on [the plaintiff's wife]" and the benefits of transfer for a certain type of surgery outweighed the risks. *Martindale*, 39 F.4th at 421. The court rejected the plaintiff's argument that "when the evidence shows the hospital could have stabilized the patient, pre-stabilization transfer could never be deemed 'appropriate.'" *Id.* at 422 (quoting 42 U.S.C. § 1395dd(c)(1)(B)). That reading was inconsistent with the text of the statute and "incompatible with the Treatment Act's narrow purpose as an anti-dumping law rather than a federal cause of action for medical malpractice." *Id.* at 423.

In sum, EMTALA's text and structure confirm Congress's understanding that not all hospitals will be able to provide all treatments. EMTALA's transfer provisions confirm that emergency departments are not required to offer "whatever" treatment a physician believes is necessary to provide stabilizing care. Instead, transfer to another hospital with different capabilities or facilities and that have the capacity cannot refuse an appropriate transfer. 42 U.S.C. § 1395dd(g)-(i). The transfer provisions would have little purpose if a hospital were required to provide "whatever" treatments its physicians deemed necessary. Their existence instead demonstrates that EMTALA contemplates that emergency departments will not all offer the treatments a physician believes is necessary stabilizing care.

3. The only specific care EMTALA requires is to protect unborn life, not end it.

As the State noted in its opening brief, the United States' argument ignores EMTALA's language regarding "unborn" children. *See* Dkt. #12-1 at 32. In response, the United States asserts that EMTALA's duty to provide stabilizing treatment only extends to the pregnant woman.[3] Dkt. #35 at 45. But the United States misses the point: 42 U.S.C. § 1395dd(e)(1) recognizes that unborn children are protected, by defining an emergency medical condition to include a situation where the unborn child's health is threatened. The Act further protects unborn children by specifying what care must be provided when such an emergency condition arises. Abortion is not on that list.[4] This Court recently agreed and rejected the United States' one-sided reading, explaining that "[t]he assumption that EMTALA implies some hierarchy when stabilization of the woman might require 'a material deterioration of the condition' of the child requires us

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[3] As detailed in footnote 1, the United States' assertion that this argument has been forfeited is incorrect. *See also* 3-ER-164-165.

[4] The United States cites to a section enacted in 2002 in Title 1. But the section it cites specifies in subsection 8(c) that the section does not take away any legal status or legal right prior to being "born alive." 1 U.S.C. § 8(c). Moreover, the Dictionary Act only applies to undefined terms. *See Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 707 (2014) (noting recourse to Dictionary Act only after finding no definition is provided). Because the health and safety of the unborn child is contemplated in the definition of "emergency medical condition," and the term "to stabilize" incorporates that definition, it follows that stabilizing care encompasses assuring that the unborn child's condition will not deteriorate. 42 U.S.C. §§ 1395dd(e)(1)(A)(i), (e)(3)(A); *see also Idaho*, 2023 WL 6308107, at *3.

to read *in* an *implicit* duty to perform abortions from the explicit duty to stabilize, which is far beyond that required for a *direct* conflict." *Idaho*, 2023 WL 6308107, at *3.

The United States further contends that the State's position would never permit an abortion. But EMTALA does not intrude on Idaho's right to determine that unborn children may not be aborted. That is why this Court emphasized EMTALA's "dual stabilization requirements," which require "hospitals [to] ensure that 'no material deterioration of the condition' of a woman or her unborn child is likely to occur." *Id.* The fact that the State has disallowed abortions that the United States believes should be permitted is simply a disagreement over policy.

4. Just because a physician wishes to perform an abortion does not mean EMTALA therefore requires it.

The United States stresses that EMTALA "leaves" the "determination" of what is "necessary stabilizing treatment" to "professionals' judgment." Dkt. #35 at 54. But it overlooks the central role state law plays in regulating professional judgment. And that point is fatal to the United States' position. In other words, if it is true that EMTALA does not disturb professional judgment regarding what constitutes necessary stabilizing treatment, the United States cannot single out for preemption state law regulating that professional judgment and defining the treatments available.

Nothing in the text of 42 U.S.C. § 1395dd gives preemptive force to a physician's preferred course of treatment. First, as discussed above, 42 U.S.C. § 1395 disclaims any intention that EMTALA is intended to establish a federal standard of care. As "[c]ourts

across the country uniformly hold," Section 1395 "prohibits Medicare regulations that 'direct or prohibit any kind of treatment or diagnosis'; 'favor one procedure over another'; or 'influence the judgment of medical professionals.'" *Texas v. Becerra*, 623 F.Supp.3d 696, 732 (N.D. Tex. 2022) (quoting *Goodman v. Sullivan*, 891 F.2d 449, 451 (2nd Cir. 1989)). The practice of medicine remains subject to state sovereignty. *Downhour v. Somani*, 85 F.3d 261, 268 (6th Cir. 1996). EMTALA does not establish a national standard of "whatever" a doctor orders.

Second, the text is clear. EMTALA sets forth an "'objective' standard of 'reasonableness.'" *Cherukuri v. Shalala*, 175 F.3d 446, 450 (6th Cir. 1999). Its requirements are grounded in "deviation from normal procedure." *Brodersen v. Sioux Valley Mem. Hosp.*, 902 F.Supp. 931, 947 (N.D. Iowa 1995) (discussing *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991)). State law, not federal law, determines what constitute "objective standards of reasonableness" and "normal procedures" for the medical field.

The United States cites cases to support the proposition that stabilizing a patient necessarily includes an abortion prohibited under Idaho law, Dkt. #35 at 33, but those cases in fact undermine the United States' position that EMTALA protects subjective judgment. In *Morin v. E. Me. Med. Ctr.*, 780 F.Supp.2d 84 (D. Me. 2010), a district court denied summary judgment under EMTALA because a pregnant woman who was having cramps was discharged before delivery of a dead unborn child. This is not an abortion under Idaho law, and it involves a stabilizing treatment that the hospital could provide. The case also undermines the United States' argument that a doctor's

subjective belief in the necessity of a procedure is coextensive with EMTALA's stabilization requirement. *Id.* at 94-95 ("EMMC's medical judgment does not trump the statute."). Likewise, *Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F.Supp.2d 696 (E.D. Mich. 2009), does not concern whether abortion was stabilizing care but whether a doctor stated a retaliation claim under EMTALA. Same with *California v. United States*, 2008 WL 744840 (N.D. Cal. 2008), which dismissed a challenge to the Weldon Amendment and did not hold that EMTALA required abortions. *Id.* at *1, *4-5. And *New York v. U.S. Dep't of Health and Human Servs.*, 414 F.Supp.3d 475 (S.D.N.Y. 2019), did not hold that emergency departments must offer abortions that a state has made illegal. *Id.* at 538-39. None of these cases support the United States' argument.

5. Idaho law does not prohibit anything EMTALA requires.

The United States labors to create a conflict where none exists. EMTALA was designed to cure a specific evil: the practice of discharging a patient unable to pay for medical treatment. Neither the court below nor the answering brief deals with Congress's intent in enacting EMTALA, whether evidenced by the congressional record or recognized by controlling circuit precedent. *See* Dkt #12-1 at 37-38 (citing *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991) (citing H.R. Rep. No. 241, 99th Cong., 2d Sess., 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605)).

Further, the district court was wrong to hold that EMTALA somehow requires abortions, which would (given the tie to Medicare funding) violate the Hyde

Amendment.[5] The purpose of EMTALA is to prohibit patient dumping—that's it. *See Idaho*, 2023 WL 6308107, at *3. A violation of the Act takes place when, after perceiving an emergency medical condition, a patient is *transferred* or *discharged* before stabilization. *Brooker*, 947 F.2d at 415. Nothing in Idaho Code § 18-622 stands as a direct conflict. Section 622 does not preclude patients of any sort from being admitted for in-patient care—which closes the door on EMTALA liability. *See Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1168 (9th Cir. 2002). Section 622 does not prohibit transfers of unstable patients to have an abortion performed elsewhere. *See Root v. New Liberty Hosp. Dist.*, 209 F.3d 1068, 1070 (8th Cir. 2000); *Burditt v. U.S. Dep't of Health and Human Servs.*, 934 F.2d 1362, 1373-74 (5th Cir. 1991). Other than the observation that EMTALA can, in other cases, preempt state law, the United States offers no further authority to support their assertion of a direct conflict. Dkt. #35 at 35.

Nor is *Matter of Baby "K"* to the contrary. 16 F.3d 590 (4th Cir. 1994). The state law preempted there allowed doctors in their subjective judgment to withhold

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[5] As detailed in footnote 1, the United States' assertion that this argument has been forfeited is incorrect. The United States' argument, Dkt. #35 at 57, regarding the Hyde-Weldon amendments is nonsensical. It relies on a statement by Representative Weldon that indicates his amendment does not prohibit treatments to save the "life" of the mother, rather than the broader circumstances the United States believes are covered. Plus such statement was made in the era of *Roe* and *Casey*, where abortion was a constitutional right. The United States' citation to 42 U.S.C. 18023(d), Dkt. #35 at 57, is inapposite, as that section does not mention a requirement to provide abortion, but only "emergency services"—again illustrating that the extension of EMTALA to require abortions is gloss on the text.

emergency treatment that was offered to others but that they believed medically or ethically inappropriate. *Id.* at 597. Despite having successfully treated Baby K with respiratory support in emergencies in the past and despite treating other patients with the respiratory support needed for Baby K, the hospital refused to provide Baby K with that available stabilizing treatment. *Id.* 593. That is not the case here: a hospital in Idaho is unable to provide the abortions at issue, and that is true for any patient. No patient risks being turned away or denied stabilizing care as a result of the law. Idaho law does not give doctors an *election* to choose not to provide stabilizing treatment—an abortion is simply not within the capacity of a hospital except when necessary as a treatment to save the life of the mother.

Finally, the United States contends that the Idaho Supreme Court held that Idaho Code § 18-622 conflicts with EMTALA. Dkt. #35 at 36. That is incorrect. The Idaho Supreme Court in *Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132 (Idaho 2023), made no such determination. The Supreme Court simply referenced the district court's injunction against Idaho Code § 18-622 "where it allegedly conflicts with EMTALA." 522 P.3d at 1161. Similarly, the United States is wrong that the State has conceded that there is some conflict between EMTALA and Idaho Code § 18-622. Dkt. #35 at 39. First, the United States confuses statements from the Legislature's counsel with the State's position. Second, the United States' assertion about those statements is misleading: the Legislature's counsel made clear that there is no "actual conflict" between the two provisions. 2-ER-118:23, -119:2. The fact that the statutes use different words to

accomplish the same task, i.e., a "conceptual textual conflict" is not a concession of preemption.

B. The United States has not shown a conflict between EMTALA and Idaho law—there is none, as Idaho law promotes EMTALA's purpose.

1. Idaho law protects the life of unborn children just like EMTALA does.

It is important to keep in mind that the "Supreme Court has found obstacle preemption in only a small number of cases. First, where the federal legislation at issue involved a 'uniquely federal area[ ] of regulation,' the Court has inferred a congressional intent to preempt state laws 'that directly interfered with the operation of the federal program.'" *In re Volkswagen "Clean Diesel" Mktg., Sales Pracs. and Prods. Liab. Litig.*, 959 F.3d 1201, 1212 (9th Cir. 2020) (quoting *Chamber of Comm. of U.S. v. Whiting*, 563 U.S. 582, (2011)). Such areas include, foreign policy, sanctioning fraud on a federal agency, and maritime law. *Id.* (collecting cases). Such areas do not include medicine, which is traditionally regulated by the several states. *See Gonzales v. Oregon*, 546 U.S. 243, 274 (2006) (noting medicine's traditional place of supervision under "States' police power."); *Harris v. N.Y. State Dep't of Health*, 202 F.Supp.2d 143 (S.D.N.Y. 2002). Second, under obstacle preemption, "a court must identify the 'full purposes and objectives' of the federal law from 'the text and structure of the statute at issue.'" *In re Volkswagen*, 959 F.3d at 1212 (quoting *Kansas v. Garcia*, 589 U.S. ___, 140 S.Ct. 791, 801 (2020)).

This is the touchstone of an obstacle preemption analysis, *Id.* at 1211 (quoting *Medtronic,* 518 U.S. at 485), and "a high threshold must be met before a court will conclude that a federal law has implied preempted a state law." *Id.* at 1212 (quoting *Whiting*, 563 U.S. at 607). The district court wandered far from these limited circumstances and stretched Congress's purpose in prohibiting patient dumping to include the establishment of a federal emergency standard of care, citing *Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001). As the opening brief pointed out, *Arrington* does not stand for this proposition. It instead confirms that "Congress has legislated to prevent patient dumping." *Id.* at 1074; *see also Bryant*, 289 F.3d at 1166. And nothing more.

Here, "[i]t is not the purpose of EMTALA to force hospitals to treat medical conditions using certain procedures." *Idaho*, 2023 WL 6308107, at *5. Because the actual purpose of EMTALA does not require the provision of any particular treatment, a state does not run afoul of the statute by regulating the provision of medicine or treatment in the state.[6] *Bryant*, 289 F.3d at 1166 ("EMTALA, however, was not enacted to establish a federal medical malpractice cause of action nor to establish a national standard of care."). To the extent EMTALA does direct emergency department treatments, Idaho Code § 18-622 promotes its purposes by ensuring that *both* a woman and her unborn child are treated in Idaho hospitals, regardless of status or ability to pay. This purpose

[6] As detailed in footnote 1, the United States' assertion that this argument has been forfeited is incorrect. 3-ER-237 (citing *Cherukuri*, 175 F.3d at 449-50).

is evident from the statutory text: risk to the unborn child is a necessary consideration before transferring a patient. 42 U.S.C. §§ 1395dd(c)(1)(A)(ii), (2)(A); *see also In re Volkswagen*, 959 F.3d at 1211 (purpose must be "grounded in the text and structure of the statute at issue.") (quoting *Garcia*, 140 S.Ct. at 804) (internal quotation marks omitted). While there is clear reference to the health of the unborn child being a necessary consideration for stabilization and transfer, there is no mention of abortion.

2. Idaho's abortion law does not interfere with EMTALA's objective of ensuring provision of emergency medical treatment regardless of financial resources.

The core purpose of EMTALA is "to prevent hospitals that receive Medicare reimbursement from refusing to provide emergency care to the indigent because of their inability to pay." *Idaho*, 2023 WL 6308107, at *3; *see also Brodersen,* 902 F.Supp. at 946 (citing *Steward v. Myrick*, 731 F.Supp. 433 (D. Kan. 1990) and collecting cases). Nothing in Idaho Code § 18-622 impedes that purpose. There is no "deviation from normal procedure" required by the act because "normal procedure" in Idaho cannot include abortion unless it is necessary to save the life of the mother. *See Brodersen,* 902 F.Supp. at 947. Because this core purpose is not interfered with, there can be no preemption.

II. The United States Cannot Meet The Other *Winter* Factors.

The United States' answering brief underscores that its entire case hinges on likelihood of success on the merits, which it failed to show. Its attempt to show irreparable harm depends on its showing that Idaho law "directly conflicts with EMTALA" and

thus "violate[s] the Supremacy Clause." Dkt. #35 at 62; *accord* Dkt. #35 at 63. And so because the United States has failed to show either an impossibility or a purposes-and-objectives conflict between EMTALA and Idaho law, it necessarily cannot show irreparable harm.

The same goes with the balance of harms, which, as the United States acknowledges, merges with the public interest in a case involving the government. Dkt. #35 at 65 (citing *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014)). That balancing of harms weighs the United States' interest in enforcing its laws (which the district court credited) against Idaho's interest in enforcing its laws (which it did not). 1-ER-051. But because federal law does not preempt Idaho's abortion laws, the United States has no irreparable harm, and instead the harm solely impacts Idaho, which has lost the opportunity to enforce its valid laws. "The district court's injunction prevents Idaho from enforcing section 622 as enacted by representatives of its people." *Idaho*, 2023 WL 6308107, at *5. Further, the United States' emphasis on the purported risks of "severe, irreparable harm to pregnant patients," Dkt. #35 at 65, without considering the impact on unborn lives, is just another proxy argument for the purported (and mistaken) conflict between federal and Idaho law. In the end then, the failure of the United States' arguments on the merits tips the balance decisively to Idaho and dooms the United States' case across the board.

The United States' forfeiture argument on this point fares no better. It says that Idaho has forfeited the argument that the lack of any federal enforcement of EMTALA

against prior Idaho law is evidence of no irreparable harm. Dkt.#35 at 64. But once again, forfeiture governs claims, not arguments, *Allen v. Santa Clara Cnty. Corr. Peace Officers Ass'n*, 38 F.4th 68, 71 (9th Cir. 2022) (citing *Pallares-Galan*, 359 F.3d at 1095), and Idaho has preserved the claim that the United States has shown no irreparable harm and is not likely to prevail. Those two points should have precluded the United States from showing entitlement to a preliminary injunction. Moreover, as these arguments depend only on the law, and not unknown facts, this Court can address the point regardless of the United States' objection. *See Flemming*, 26 F.4th at 1144.

III. Even On Its Own Terms, The Injunction Is Overbroad.

The United States acknowledges Idaho's principal contention regarding overbreadth by arguing that the injunction should be read to be limited only "to medical care required by [EMTALA], 42 U.S.C. § 1395dd." Dkt. #35 at 71 (quoting 1-ER-51). Indeed, to read it outside of that limitation would contemplate relief far in excess of the law. The Court should account for the parties' agreement on this limitation of the injunction in rendering its decision.

The United States contends, however, that the injunction does not exceed its limitation as an as-applied challenge that does not "reach beyond the particular circumstances of the[] plaintiff[]." *Id.* at 72 (quoting *John Doe No. 1 v. Reed*, 561 U.S. 186, 194 (2010)). But rather than addressing the particular circumstances of the United States, the injunction goes far beyond by crafting relief for any physician who might be affected by the purported conflict between state and federal law. Instead, the injunction focuses

primarily on private actors who are purportedly affected by this law—private actors who could have, but did not, sue over the purported conflict between EMTALA and Idaho law. 1-ER-051-52. That no such suit has been brought deprives the Court from adjudicating those claims in this action.

CONCLUSION

For the foregoing reasons, this Court should reverse and remand, vacating the district court's preliminary injunction.

Respectfully submitted,

September 29, 2023.

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CERTIFICATE OF COMPLIANCE FOR BRIEFS

9th Circuit Case No.: 23-35440 (consolidated with 23-35450)

I am the attorney representing Appellant.

This brief contains 5,952 words, including 0 words manually counted in any visual images, and excluding the items exempted by FRAP 32(f). The brief's type size and typeface comply with FRAP 32(a)(5) and (6).

I certify that this brief complies with the word limit of Cir. R. 32-1.

/s/ Joshua N. Turner September 29, 2023

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing/attached documents on this date with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit using the Appellate Electronic Filing system.

Description of Documents: Appellant's Reply Brief

/s/ *Joshua N. Turner* September 29, 2023