Nos. 23-726, 23-727

In the Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL., PETITIONERS,
v.
UNITED STATES

IDAHO, PETITIONER,
v.
UNITED STATES

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR *AMICI CURIAE* LEGAL SCHOLARS SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, preempts Idaho law in the narrow but important circumstance where terminating a pregnancy is required to stabilize an emergency medical condition that would otherwise threaten serious harm to the pregnant woman's health but the State prohibits an emergency-room physician from providing that care.

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INTERESTS OF *AMICI CURIAE*[1]

Amici are professors and scholars who study, teach, and write about health law and policy and related subjects. *Amici* are well-versed in this Court's precedents regarding public health law and federalism. They file this brief to provide the Court with information about the historic interpretations of EMTALA and this Court's consistent application of traditional preemption principles to Spending Clause statutes like EMTALA.

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[1] No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation of or submission of this brief. No one other than the *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

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INTRODUCTION AND SUMMARY OF ARGUMENT

Petitioners fundamentally misunderstand the Emergency Medical Treatment and Labor Act ("EMTALA"). Operating under that misunderstanding, they insist that this Court must determine EMTALA's preemptive effect using a clear-statement rule rather than traditional tools of statutory interpretation. According to petitioners, Congress needed to say that terminating a pregnancy, specifically, is an emergency treatment in some cases. Petitioners are wrong.

At the urging of physicians, the Congress that enacted EMTALA in 1986 chose to define the "stabilizing" treatments required in certain medical emergencies by incorporating clinical guidelines, rather than by attempting to list procedures. In 1986, terminating a pregnancy was a permitted medical treatment not only to save a patient's life, but also to prevent substantial risks to her health. Even states that banned third-trimester abortions exempted abortion "to preserve the life *or health* of the woman." *E.g.*, Wisc. Stat. § 940.15(2)-(3) (1985) (emphasis added). It is no surprise, therefore, that since EMTALA's enactment, practitioners have acknowledged their statutory obligation to provide

abortion care in those rare emergencies in which terminating a pregnancy is the necessary "stabilizing" treatment. That is how "most people * * * would have understood" the statutory language when it was enacted. *New Prime Inc.* v. *Oliveira*, 139 S. Ct. 532, 539 (2019).

After *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), HHS Secretary Xavier Becerra issued a Guidance letter reminding doctors "[i]f a physician believes * * * that abortion is the stabilizing treatment necessary" in a particular emergency, and such treatment is medically appropriate, the hospital must provide that treatment. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* 1 (July 11, 2022) ("Guidance"), https://perma.cc/GT5D-Q9FN. The Guidance says nothing about non-emergency abortion, and it does not impose an "abortion mandate." It says only that terminating a pregnancy *may be* "stabilizing" treatment in certain emergencies, depending on medical judgment.

Against this backdrop, the major questions doctrine has no place in this case. The Guidance is a routine exercise of HHS's authority to remind Medicare recipients of their obligations under EMTALA. Because EMTALA incorporates clinical guidelines, and because terminating a pregnancy has long been considered appropriate emergency treatment under certain circumstances, the Guidance is anything but an "unheralded" and "transformative" interpretation of the statute. EMTALA's stabilization requirement has *always* been understood to encompass terminating a pregnancy when the procedure has a "reasonable medical probability" of preventing a material deterioration in the patient's condition. 42 U.S.C. § 1395dd(e)(3)(A). HHS has not changed anything; it simply reminded hospitals that EMTALA requires what it has always required,

notwithstanding *Dobbs*. Petitioners cannot circumvent EMTALA's text and history by recasting the Guidance as a regulation of non-emergency abortion, or by invoking the economic significance of Medicare as a whole.

Nor can petitioners impose a clear statement rule on EMTALA simply because it was enacted as part of a federal spending program. Time and again, this Court has assessed the preemptive effect of Spending Clause statutes as it would any other statute—by determining the reading that "best comports with [the statutory] text, context, and purpose." *Coventry Health Care of Mo., Inc.* v. *Nevils*, 581 U.S. 87, 95 (2017). "A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect." *Wos* v. *E.M.A. ex rel. Johnson*, 568 U.S. 627, 636 (2013). EMTALA's preemptive effect could not be clearer; it expressly "preempt[s] any State or local law requirement * * * to the extent that the requirement directly conflicts with a requirement of" EMTALA. 42 U.S.C. § 1395dd(f).

Finally, petitioners cannot impose a clear statement rule on EMTALA by invoking the Tenth Amendment and principles of federalism. Medicare reflects a *national* prerogative. It embodies the rejection of "state-based deviation" in healthcare. Nicole Huberfeld, *Federalizing Medicaid*, 14 U. Pa. J. Const. L. 431, 449 (2011).

The Court should determine EMTALA's preemptive effect the way it would determine the preemptive effect of any other statute; using ordinary tools of statutory interpretation. Applying these tools, the Court should affirm.

ARGUMENT

WHETHER EMTALA PREEMPTS IDAHO LAW SHOULD BE DETERMINED THROUGH ORDINARY TOOLS OF STATUTORY INTERPRETATION

A. The Major Questions Doctrine Does Not Apply

The major questions doctrine does not require a clear statement that abortion, specifically, is among the treatments EMTALA authorizes. In enacting a statute that requires hospitals to provide stabilizing treatment in medical emergencies, Congress incorporated professional judgments and prevailing clinical guidelines into the definition of "stabilization." And Congress clearly contemplated that "reasonable medical probability" can include terminating a pregnancy in certain rare cases.

1. The major questions doctrine does not apply in this case, because HHS's Guidance falls squarely within the agency's purview under the statute, and Congress was not required to specifically list abortion as an authorized treatment. Pregnancy termination has long been recognized as necessary emergency treatment in certain circumstances. No one in Congress in 1986 would have been surprised to learn that physicians are occasionally required to terminate a pregnancy to protect patients from serious harm.

The major questions doctrine exists to prevent "one branch of government arrogating to itself power belonging to another." *Biden* v. *Nebraska*, 143 S. Ct. 2355, 2373 (2023). The doctrine applies when the "'history and the breadth of the authority that [the agency] has asserted,' and the 'economic and political significance' of that assertion, provide a 'reason to hesitate before concluding that Congress' meant to confer such authority." *West Virginia* v. *EPA*, 597 U.S. 697, 721 (2022) (quoting *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159-160 (2000)). In other words, the doctrine

applies when an agency adopts an "unheralded" interpretation of a statute that would "represent[] a 'transformative expansion in [its] regulatory authority.'" *Id.* at 724 (quoting *Util. Air Regul. Grp.* v. *EPA*, 573 U.S. 302, 324 (2014)).

The major questions doctrine is *not* triggered when an agency applies a statute to a discrete situation that clearly falls within the statutory terms. Nor does the doctrine apply when an agency exercises authority that Congress would reasonably have anticipated given the subject matter of the statute and the regulatory authority and expertise of the agency. For example, the doctrine does not apply when a federal agency promulgates the type of rule it "routinely imposes," even when the rule involves a politically sensitive subject. *Biden* v. *Missouri*, 595 U.S. 87, 94 (2022). That is why, in *Biden* v. *Missouri*, the Court did not apply the doctrine when the HHS Secretary required staff of facilities receiving Medicare and Medicaid funding to get COVID-19 vaccines. The Court explained that "the Secretary routinely imposes conditions of participation [in Medicare and Medicaid] that relate to the qualifications and duties of healthcare workers themselves." *Ibid.* The vaccine mandate did not trigger the major questions doctrine because it was consistent with the Secretary's authority to promulgate "requirements as [he] finds necessary in the interest of * * * health and safety." *Id.* at 90 (quoting statutes).

2. EMTALA's text and history show that Congress would have expected that abortions might occasionally be required under the statute. As a consequence, nothing in the Secretary's interpretation of EMTALA—which merely reiterates the statutory requirements—"represent[s] a 'transformative expansion in [HHS's] regulatory authority.'" *West Virginia*, 597 U.S. at 724 (quoting *Util. Air*, 573 U.S. at 324). To the contrary, the Secretary's interpretation of EMTALA reflects HHS's

traditional "core mission" of "ensur[ing] that the healthcare providers who care for Medicare * * * patients protect their patients' health and safety." *Biden* v. *Missouri*, 595 U.S. at 90.

The Secretary does not claim that EMTALA permits HHS to require hospitals to perform non-emergency abortions or regulate outside the limited context of medical emergencies. Rather, the Guidance clarifies that abortion is, in some cases, the appropriate "stabilizing" treatment in an emergency. EMTALA requires hospitals to provide treatments with a "reasonable medical probability" of preventing patients' conditions from deteriorating in such emergencies, 42 U.S.C. § 1395dd(e)(3)(A), rather than "dumping" those patients. See *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (citing H.R. Rep. 99-241, pt. 1, at 27 (1985)). The Secretary interprets this to mean that if, under prevailing standards of care, "stabilization" necessitates termination of a patient's pregnancy, EMTALA requires hospitals to provide that treatment rather than turning patients away. 42 U.S.C. § 1395dd(b)(1)(A). This is far from a "transformative expansion in [the Secretary's] regulatory authority.'" *West Virginia*, 597 U.S. at 724. Rather, it falls squarely within the Secretary's authority to promulgate "requirements as [he] finds necessary in the interest of * * * health and safety," just as the Secretary's imposition of a vaccine mandate for healthcare workers "is what he does." *Biden* v. *Missouri*, 595 U.S. at 90 (quoting statutes).

3. Unlike in the Court's major questions cases, there is no reason for "skepticism" that the Secretary's interpretation of EMTALA falls into the range of interpretations Congress authorized. *West Virginia*, 597 U.S. at 724. Congress would have understood that a range of medical procedures, including abortion, could be

necessary stabilizing care. When Congress enacted EMTALA, it declined to list each *type* of treatment that counts as "stabilization." EMTALA does not specify *any* medical procedures that might qualify as necessary in medical emergencies. Instead, it defines "stabiliz[ation]" as encompassing whatever treatment has a "reasonable medical probability" of preventing a material deterioration in the patient's condition. 42 U.S.C. § 1395dd(e)(3)(A). It is established clinical guidelines and professional judgments, not EMTALA itself, that determine which particular treatments count as "stabilization."

Incorporating established clinical guidelines, rather than listing covered conditions, was deliberate and necessary. Early iterations of the bill did not include language deferring to medical judgments. *E.g.*, Deficit Reduction Amendments of 1985, H.R. 3128, § 124, 99th Cong. (1985). But after emergency physicians expressed concerns, see, *e.g.*, H.R. Rep. 99-241, pt. 3, at 745 (1985) (statement of Am. Coll. of Emergency Physicians), Congress revised the text to define "stabilizing" treatment in terms of the professional standard, 42 U.S.C. § 1395dd(e)(3)(A); see H.R. Rep. No. 99-453, at 477-478 (1985) (Conf. Rep.) ("The conference agreement includes the House bill with two modifications from the Senate amendment: the condition must be an emergency medical condition, and the assurance that no material deterioration of the medical condition is likely to result must be within reasonable medical probability."). This saved Congress from the impossible task of "anticipat[ing]" what procedures would meet medical care standards in years to come. See Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 Annals Health L. 145, 160 (2004).

The backdrop against which EMTALA was enacted underscores Congress's understanding that "stabilizing" treatment encompasses pregnancy termination not only to protect a patient's *life*, but also to protect her *health*. By the time this Court decided *Roe* v. *Wade*, 410 U.S. 113 (1973), many states that otherwise proscribed abortion nevertheless permitted abortion to preserve the health of the woman, or had adopted a version of the Model Penal Code of 1962, which allowed abortion when "there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother." Model Penal Code § 230.3(2) (1962).[2]

And when Congress enacted EMTALA, even states that banned third-trimester abortions expressly exempted cases involving substantial risk to the health of the patient. For example, in 1985, Wisconsin enacted a law criminalizing "abortion after the fetus or unborn child reaches viability," except "if the abortion is necessary to preserve the life *or health* of the woman, as determined by reasonable medical judgment of the woman's attending physician." Wisc. Stat. § 940.15(2)-(3) (1985) (emphasis added). Likewise, in 1987, Texas enacted a law banning third-trimester abortion unless, "according to the physician's best medical judgment," an "abortion is necessary to prevent the death *or a substantial risk of serious impairment* to the physical or mental health of the woman." H.B. 410, 70th Leg., Reg. Sess., 1987 Tex. Sess. Law Serv. ch. 469 (emphasis added); see also, *e.g.*, Abortion Control Act, June 11, 1982, P.L. 476, No. 138, as amended, 18 Pa. C.S. §§ 3201, 3203 (1982) (restricting abortion access with exception for when, in the "physician's good faith clinical judgment," terminating a

[2] See Paul Benjamin Linton, *The Legal Status of Abortion in the States If* Roe v. Wade *Is Overruled*, 23 Issues L. & Med. 3 (2007) (surveying pre-*Roe* abortion bans).

pregnancy is necessary to prevent death *or* "serious risk of substantial and irreversible impairment of major bodily function"). There is no "reason to hesitate" before concluding that EMTALA's stabilization requirement includes treatments that were expressly permitted when EMTALA was enacted, even in states that otherwise banned third-trimester abortion. *West Virginia*, 597 U.S. at 724 (citation omitted). Rather, that is how "most people then would have understood" the statutory language. *New Prime Inc.* v. *Oliveira*, 139 S. Ct. 532, 539 (2019); see, *e.g.*, *Wisconsin Cent. Ltd.* v. *United States*, 585 U.S. 274, 277 (2018).[3]

4. Against the backdrop of EMTALA's text and history, the Guidance here is anything but "transformative" and "unheralded." The Secretary simply said in interpreting EMTALA that "[i]f a physician believes * * * that abortion is the stabilizing treatment necessary," and such treatment is in fact medically appropriate, the hospital must provide that treatment. Guidance at 1. In other words, the Guidance merely reiterates what everyone already knew about EMTALA: that terminating a pregnancy can be appropriate medical care when the procedure has a "reasonable medical probability" of preventing a material deterioration in the patient's condition. 42 U.S.C. § 1395dd(e)(3)(A).

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[3] When it comes to defining "emergencies," Congress expressly rejected a "life endangerment" standard in favor of one that applies to conditions that "plac[e] the patient's health in serious jeopardy." H.R. Rep. 99-453, at 476 (1985) (Conf. Rep.); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 167 (1986). In other words, Congress was clear that an emergency is a serious threat to health—rather than threat to life—and the measures necessary to "stabilize" a patient in such an emergency depend on professional standards, whatever those standards require.

In fact, the Secretary's interpretation of EMTALA is demonstrably "[]heralded." For example, in the section of the Affordable Care Act creating a "State opt-out of abortion coverage," Congress expressly noted that, despite the opt-out provision, the statute does not "relieve any health care provider from providing emergency services as required by * * * 'EMTALA'[]." 42 U.S.C. § 18023(a), (d). HHS, in turn, has long interpreted the statute to require hospitals to "perform[] abortions that are necessary to stabilize the mother, as that term has been interpreted in the context of EMTALA." 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008).

Likewise, providers have always understood that, under EMTALA, "the appropriate stabilizing treatment for some medical conditions experienced by pregnant patients is termination of pregnancy." J.A. 591-592; J.A. 29-30; J.A. 617; J.A. 612; see *Ritten* v. *Lapeer Reg'l Med. Ctr.*, 611 F. Supp. 2d 696, 709 (E.D. Mich. 2009) (provider refused to transfer a patient, believing that EMTALA required termination of her pregnancy). And when practitioners have refused to provide abortions necessary under prevailing standards of care, patients have sued under 42 U.S.C. § 1983 alleging violations of EMTALA. See, *e.g.*, *Lee* v. *Trail*, No. 99-CV-1455 (DEW), Dkt. 1 at 1 (W. D. La. Aug. 11, 1999).

Finally, proposed legislation to "prevent[] Federal funding" to hospitals that require physicians "to participate in *elective* abortions" has been defended on the ground that EMTALA's stabilization requirement protects patients in need of emergency abortions. 151 Cong. Rec. H177 (Jan. 25, 2005) (statement of Rep. Weldon) (emphasis added). In other words, it is commonly understood that EMTALA "requires that an abortion be provided" in medical emergencies when it would "stabilize the medical condition of [pregnant] patients." *Ibid.* The Guidance, therefore, does exactly what it says: "*remind*

hospitals of their existing obligation to comply with EMTALA." Guidance at 1 (emphasis added).

5. Nor does the Guidance claim an "[e]xtraordinary grant[] of regulatory authority" or seek to resolve an issue of "vast economic and political significance." *West Virginia*, 597 U.S. at 716, 723. The Guidance comes into play only in narrow circumstances, when a medical emergency requires pregnancy termination to protect a patient's life or health. The Guidance merely clarifies that, when terminating a pregnancy meets professional standards for "stabilization" in certain emergencies, EMTALA requires hospitals to comply rather than turning patients away. It does not permit people to seek—or mandate that hospitals provide—*non-emergency* abortions.

6. Petitioners' attempt to recast the Guidance as addressing a question of "vast economic and political significance," Leg. Br. 38 (quotation marks omitted), fundamentally misstates the question the Secretary actually answered. According to petitioners, the Secretary has "supplanted" "decades-long lawmaking on abortion" and issued "the final word on the availability of abortion in most hospitals nationwide." Leg. Br. 39-40.

But as discussed, the Secretary has not interpreted EMTALA to require non-emergency abortions—the Guidance clarifies only that terminating a pregnancy *can* be necessary in medical emergencies to protect a patient's health. Nor has the Secretary interpreted EMTALA to create an "abortion mandate," as petitioners insist. Leg. Br. 25. Again, the Guidance merely explains that hospitals are obligated to terminate a pregnancy when—under established clinical guidelines—doing so is necessary to "stabiliz[e]" a patient with an "emergency medical condition." Guidance at 1; 42 U.S.C. § 1395dd(b)(1)(A). The issue of whether EMTALA applies to *emergency* abortions in a small class of cases, when necessary to save

the life or health of the patient, is not a question of vast political significance. The Secretary certainly did not, as petitioners assert, "supplant[]" "decades-long lawmaking on abortion." Leg. Br. 39.

Petitioners also get things backward when they call the Guidance a "sudden[]" change of direction "[o]n the heels of *Dobbs*." Leg. Br. 42. EMTALA has always required physicians to provide stabilizing treatment in line with the applicable clinical guidelines. *Dobbs* overruled this Court's cases recognizing a constitutional *right* to abortion, but it said nothing about whether abortion is the appropriate procedure in certain medical emergencies. The Guidance reminded hospitals of their obligations not because the government's interpretation of *EMTALA* changed, but because the legal landscape around abortion changed suddenly, generating confusion. Indeed, this case is proof that the new Guidance was necessary, given Idaho's position that it has the power to *prevent* physicians from providing care that clinical guidelines indicate is medically necessary, notwithstanding EMTALA's clear mandate.

7. Finally, the Secretary's interpretation of EMTALA is not a decision of vast *economic* significance. Requiring hospitals to comply with prevailing standards of care regarding "stabilization," in rare emergency situations, will warrant abortion care only in a tiny fraction of cases. Contrary to petitioners' assumption, Leg. Br. 40-41, economic significance for purposes of the major questions doctrine concerns the cost of compliance with a federal program, not the cost of *noncompliance*. See *Biden* v. *Nebraska*, 143 S. Ct. 2355, 2373 (2023). The "economic significance" inquiry stems from courts' inherent "skepticism" of "assertions of extravagant statutory power over the national economy," *West Virginia*, 597 U.S. at 724 (quotation marks omitted), such as when agencies "place plainly excessive demands on limited

governmental resources," *Util. Air*, 573 U.S. at 323-324. In *Biden* v. *Nebraska*, for example, the Department of Education triggered the major questions doctrine when it sought to excuse "$430 billion in student loans," because "[t]he Secretary ha[d] never previously claimed powers of this magnitude under the HEROES Act." 143 S. Ct. 2355, 2372-2373 (2023).

But courts are not inherently skeptical of agencies acting within the basic Medicare framework. And the Secretary has *long* had power to place conditions on Medicare funding; there is nothing "unheralded" about that.

* * * * *

The Congress that enacted EMTALA plainly contemplated that pregnancy termination could be necessary in medical emergencies. Because the Guidance is a routine exercise of HHS's authority, does not reflect an "unheralded" and "transformative" interpretation of EMTALA, and does not decide a question of "vast economic and political significance," it does not trigger the major questions doctrine. If it did, few cases would not.

B. Whether EMTALA Preempts State Law Turns On Ordinary Tools Of Statutory Interpretation

Just like other federal laws, EMTALA's preemptive effect on contrary state laws is a matter of ordinary statutory interpretation. Under that familiar framework, EMTALA clearly preempts state criminal laws that proscribe certain forms of necessary emergency medical care in hospitals that receive Medicare funds. Congress did not need to single out "abortion" as one of the myriad treatments EMTALA may require in certain medical emergencies. And EMTALA's preemption clause removes any doubt that the statute preempts contrary state criminal laws.

1. Courts evaluate the preemptive force of statutes using conventional statutory interpretation—in other words, "much as [they] would any [question] about statutory meaning, looking to the text and context of the law in question and guided by the traditional tools of statutory interpretation." *Virginia Uranium, Inc.* v. *Warren*, 139 S. Ct. 1894, 1901 (2019). "When the existence of pre-emption is evident from the statutory text," the "inquiry must begin and end with the statutory framework itself." *Gade* v. *National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 111 (1992) (Kennedy, J., concurring in part and concurring in the judgment); see *National Meat Ass'n* v. *Harris*, 565 U.S. 452 (2012) (comparing the text of federal and state statutes to determine that the Federal Meat Inspection Act expressly preempted a California law that also regulated slaughterhouse facilities and operations).

This traditional preemption analysis applies equally to Spending Clause statutes. For example, in *Lawrence County* v. *Lead-Deadwood School District No. 40-1*, 469 U.S. 256 (1985), the Court had "little trouble" concluding that a federal statute that allows local governments to use certain federal funds for "any governmental purpose" preempted a South Dakota statute that required the payments to be distributed as general tax revenues. *Id.* at 268. In reaching that conclusion, the Court reviewed the "plain language" of the federal statute and "other indicia of the meaning of the statutory language." *Id.* at 261. Likewise, in *Wos* v. *E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013), the Court held that the Medicaid Act's anti-lien provision preempted a conflicting state law. *Id.* at 636 (citing *PLIVA, Inc.* v. *Mensing*, 564 U.S. 604, 617 (2011)). The Court explained that "[a] State may not evade the pre-emptive force of federal law by resorting to creative

statutory interpretation or description at odds with the statute's intended operation and effect." *Id.*[4]

This traditional preemption analysis also applies to Spending Clause legislation that regulates private entities. In *Coventry Health Care of Missouri, Inc.* v. *Nevils*, 581 U.S. 87, 90 (2017), for example, the Court held that the Federal Employees Health Benefits Act, which authorizes the Office of Personnel Management to contract with "private carriers" for federal employees' health insurance, preempted state laws that barred enforcement of contractual subrogation and reimbursement provisions. The Court explained that although the states' "construction [of FEHBA as non-preemptive was] 'plausible,' the reading advanced [in favor of preemption] best comport[ed] with [FEHBA's] text, context, and purpose." *Id.* at 95; see *Health & Hosp. Corp. of Marion Cnty.* v. *Talevski*, Br. of United States as *amicus curiae*, 2022 WL 3006297, at *17 (citing *Nevils* for the proposition that "the Court has repeatedly held that Spending Clause legislation preempts conflicting state law").

In other words, the preemptive effect of a Spending Clause statute turns on the best reading of the law. Courts do not strain the text to vindicate anti-preemption or anti-spending policies. See *Biden* v. *Nebraska*, 143 S. Ct. 2355, 2377 (2023) (Barrett, J., concurring) (noting that such

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[4] See also *Townsend* v. *Swank*, 404 U.S. 282, 285 (1971) (applying conventional statutory interpretation principles to conclude that the state laws that conflicted with the Social Security Act were "invalid under the Supremacy Clause"); *Blum* v. *Bacon*, 457 U.S. 132, 137-138 (1982) (same); *Philpott* v. *Essex Cnty. Welfare Bd.*, 409 U.S. 413, 415-417 (1973) (same); *Bennett* v. *Arkansas*, 485 U.S. 395, 397 (1988) (same); *California Dep't of Hum. Res. Dev.* v. *Java*, 402 U.S. 121, 135 (1971) (same); *Carleson* v. *Remillard*, 406 U.S. 598, 601-604 (1972) (similar); *Norfolk S. Ry. Co. v. Shanklin*, 529 U.S. 344, 358-59 (2000) (similar).

"substantive canons" "are in significant tension with textualism insofar as they instruct a court to adopt something other than the statute's most natural meaning" (quotation marks omitted)); cf. *Health & Hosp. Corp. of Marion Cnty.* v. *Talevski*, 599 U.S. 166, 171-172 (2023) ("'Laws' mean 'laws'" and there is no "implicit carveout for laws that Congress enacts via its spending power.").

2. When "the statute contains an express pre-emption clause, the task of statutory construction must in the first instance focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *CSX Transport., Inc.* v. *Easterwood*, 507 U.S. 658, 664 (1993). EMTALA expressly "preempt[s] any State or local law requirement * * * to the extent that the requirement directly conflicts with a requirement of" the statute, 42 U.S.C. § 1395dd(f), so it is no surprise that courts have always determined EMTALA's preemptive effect using traditional preemption principles. In *Matter of Baby K*, 16 F.3d 590 (4th Cir. 1994), for example, EMTALA's "stabilization" requirement preempted a Virginia law that allowed physicians to refuse medical care they deemed unethical. *Id.* at 597. The court explained that "[i]t is well settled that state action must give way" to federal law when there is an actual conflict. *Ibid.* Similarly, the court in *Root* v. *New Liberty Hospital District*, 209 F.3d 1068 (8th Cir. 2000), held that "[t]he supremacy clause * * * dictate[d] that Missouri's sovereign immunity statute must yield" to EMTALA where the two were "in direct conflict." *Id.* at 1070.[5] There

[5] See also *Hardy* v. *New York City Health & Hosp. Corp.*, 164 F.3d 789, 794-795 (2d Cir. 1999) (applying traditional preemption principles to EMTALA); *Draper* v. *Chiapuzio*, 9 F.3d 1391, 1393-1394 (9th Cir. 1993) (similar); *Deberry* v. *Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990) (reviewing EMTALA's text to determine its preemptive effect); *Bird* v. *Pioneers Hosp.*, 121 F. Supp. 2d 1321, 1323-26 (D. Colo. 2000) (holding that EMTALA's

is no reason to discard traditional tools of statutory interpretation in assessing EMTALA's preemptive effect.

Petitioners claim that because EMTALA's "preemption provision is phrased in the negative * * * [t]hat syntax renders the provision a non-preemption clause." Leg. Br. 22. But this argument ignores the key difference between EMTALA's preemption clause and "non"-preemption clauses. A non-preemption clause *forecloses* preemption. For example: "Nothing in this section shall be construed to affect the authority of any State or local agency to regulate activities for purposes other than protection against radiation hazards." *Warren*, 139 S. Ct. at 1902. Or: "Nothing in this section shall be construed to modify or otherwise affect any action or the liability of any person under the product liability law of any State." 21 U.S.C. § 379r(e); see *Mutual Pharmaceutical Co., Inc.* v. *Bartlett*, 570 U.S. 472, 493 (2013) (citing this provision as an example of an "express non-pre-emption clause"). EMTALA's preemption clause, by contrast, says the statute *does* preempt state law "to the extent that the [state law] requirement directly conflicts with a requirement of" EMTALA. 42 U.S.C. § 1395dd(f).

3. Petitioners also argue the preemption power asserted under EMTALA "would exceed Congress's power to influence policy by spending," because spending conditions "must be accepted 'voluntarily and knowingly' and Congress must attach such conditions 'unambiguously.'" Leg. Br. 49-50 (quoting *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981)). Petitioners claim that by offering funds to hospitals

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statute of limitations preempted conflicting state procedural requirements); *Merce* v. *Greenwood*, 348 F. Supp. 2d 1271, 1273-1276 (D. Utah 2004) (similar).

through Medicare, EMTALA is somehow coercing *States* to adopt a particular policy. Leg. Br. 49-50.

But Petitioners' reliance on the "coercion" doctrine is misplaced. The only time this Court has found improper coercion in a spending program was in the *Medicaid* context, which, unlike Medicare, involves funds provided directly to States. See *NFIB* v. *Sebelius*, 567 U.S. 519, 580-585 (2012) (plurality opinion). The "gun to the head" in *NFIB* involved "threats to terminate * * * significant independent grants" to States, thereby "pressuring *the States* to accept policy changes." *Id.* at 580-581 (emphasis added). But where, as here, a Spending Clause statute involves funds to a local or private, rather than state, entity, this Court conducts a standard preemption analysis. See, *e.g.*, *Nevils*, 581 U.S. at 90-91, 95 (federal law controlling government contracts with private entities preempted conflicting state contract laws); *Lead-Deadwood*, 469 U.S. at 258-259 (federal statute regulating "local [government] unit" preempted a South Dakota law). And in any event, the Court in *NFIB* found changes to Medicaid went further than "[p]revious amendments to Medicaid eligibility." *Id.* at 583. Here, by contrast, the Guidance reminds hospitals of requirements that have *always* been part of EMTALA.

4. Finally, Petitioners urge the Court to apply a clear statement rule under *Gregory* v. *Ashcroft*, 501 U.S. 452 (1991), "to preserve the Constitution's 'dual system of sovereignty.'" Leg. Br. 53 (quoting *Gregory*, 501 U.S. at 457). But *Gregory*'s clear-statement rule stems from the premise that "Congress does not exercise [its legislative power] lightly" in "areas traditionally regulated by the States." *Gregory*, 501 U.S. at 460. Because "Congress does not readily interfere" in these "areas," the "plain statement rule is nothing more than an acknowledgment that the States retain substantial sovereign powers under our constitutional scheme." *Id.* at 461.

Medicare, however, reflects a purposefully *national* approach. It embodies the notion that, in this federal healthcare program, "state-based deviation was rejected." Nicole Huberfeld, *Federalizing Medicaid*, 14 U. Pa. J. Const. L. 431, 449 (2011). And "there is no question that the Federal Government can set uniform national standards" for "health and safety." *Gonzales* v. *Oregon*, 546 U.S. 243, 271 (2006). Petitioners' insistence on a clear-statement rule to vindicate a misplaced view of federalism is merely "an aggressive use of clear statement rules [to] violate[] the baseline rule of legislative supremacy." Amy Coney Barrett, *Substantive Canons and Faithful Agency*, 90 B.U. L. Rev. 109, 166-167 (2010).

CONCLUSION

The Court should affirm.

Respectfully submitted.

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