No. 23-35440, 23-35450

# UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

 $\nu$ .

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

# STATE OF IDAHO'S EXCERPTS OF RECORD INDEX VOLUME

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# UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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### STATE OF IDAHO'S EXCERPTS OF RECORD Volume 1 of 3

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# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

THE UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant,

SCOTT BEDKE, in his official capacity as Speaker of the House of Representatives of the State of Idaho; CHUCK WINDER, in his capacity as President Pro Tempore of the Idaho State Senate; and the SIXTY-SIXTH IDAHO LEGISLATURE,

Intervenor-Defendants

Case No. 1:22-cv-00329-BLW

MEMORANDUM DECISION AND ORDER

#### INTRODUCTION

Idaho Code § 18-622 makes it a felony for anyone to perform or attempt to perform or assist with an abortion. Idaho Code § 18-622(2). The law, which the Idaho Supreme Court refers to as the "Total Abortion Ban," criminalizes *all* abortions, without exception – offering only the "cold comfort" of two narrow affirmative defenses.

\*Memorandum Decision and Order dated August 24, 2022, p. 1, Dkt. 95. As relevant here,

an accused physician may avoid *conviction* when the physician determines in her good faith medical judgment that the abortion is necessary to prevent the death of a pregnant woman. *Id.* § 18-622(3). The affirmative defense does not protect a physician who performs an abortion "merely" to prevent serious harm to the patient, rather than to save her life. Nor does the affirmative defense insulate the physician from criminal *prosecution* under any circumstances. Instead, it shifts the burden of proof from the prosecution to the criminal defendant to prove at trial that the abortion was necessary to prevent the death of the mother – in a sense, presuming the defendant guilty until she proves herself innocent.

The Total Abortion Ban, even before it went into effect, has engendered various legal challenges in both federal and state court. In this Court, the United States sued to enjoin the ban to the extent it conflicted with the federal Emergency Medical Treatment and Labor Act ("EMTALA"), which requires hospitals that accept Medicare funds to offer stabilizing treatment—including, in some cases, treatment that would be considered an abortion—to patients who present at emergency departments with emergency medical conditions. Because the Total Abortion Ban criminalizes medical care that federal law requires hospitals to offer, this Court enjoined Idaho Code § 18-622 to the extent it conflicts with EMTALA. See Memorandum Decision and Order, dated August 24, 2022 ("August 24, 2022 Injunction"). Rather than appealing this decision the State of Idaho and the Idaho Legislature have filed motions for reconsideration, which are now pending before the Court. (Dkt. 97 & 101).

Parallel to this litigation, a challenge to the constitutionality of the ban under the Idaho Constitution proceeded separately before the Idaho Supreme Court. *Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky. v. State ("Planned Parenthood")*, Idaho Supreme Court Docket No. 49817-2022 (Idaho June 27, 2022) (Petition for Writ of Prohibition). On January 5, 2023, while the motions for reconsideration remained pending, the Idaho Supreme Court issued its decision in *Planned Parenthood*, upholding the constitutionality of the Total Abortion Ban under the Idaho Constitution. *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132 (2023). The Idaho Supreme Court also construed the scope of Idaho's Total Abortion Ban in rendering its decision.

After the Idaho Supreme Court issued its decision in *Planned Parenthood*, both the State and the Legislature requested to file supplemental briefing in support of their motions for reconsideration. This Court granted their request. Now, in addition to their arguments raised in their initial round of briefing, both the State and the Legislature argue that the *Planned Parenthood* decision eliminated any conflict between EMTALA and the Total Abortion Ban, obviating any need for the preliminary injunction entered in this case. *See* Dkts. 126, 127. As explained below, the Court will deny the motions for reconsideration.

#### **ANALYSIS**

#### 1. Motion to Reconsider Standard

"Reconsideration is an extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources." *Adidas Am., Inc. v. Payless Shoesource, Inc.*, 540 F. Supp. 2d 1176, 1179 (D. Or. 2008) (quoting *Kona Enterprises*,

Inc. v. Estate of Bishop, 229 F.3d 877, 890 (9th Cir. 2000)) (internal quotation marks omitted); see also Carroll v. Nakatani, 342 F.3d 934, 945 (9th Cir. 2003). A motion to reconsider should therefore be granted only if the moving party can show an intervening change in controlling law, new evidence has become available, or the district court committed clear error, or the initial decision was manifestly unjust. See Cachil Dehe Band of Wintun Indians of Colusa Indian Community v. California, 649 F.Supp.2d 1063, 1069-70 (E.D. Cal. 2009) (citing Sch. Dist. No. 1J Multnomah County, Or. v. ACandS, Inc., 5 F.3d 1255, 1263 (9th Cir. 1993)).

"Motions for reconsideration are generally disfavored, and, in the absence of new evidence or change in the law, a party may not use a motion to reconsider to present new arguments or evidence that could have been raised earlier." *Adidas*, 540 F. Supp. 2d at 1180 (citing *Fuller v. M.G. Jewelry*, 950 F.2d 1437, 1442 (9th Cir. 1991)). "Motions to reconsider are also not vehicles permitting the unsuccessful party to 'rehash' arguments previously presented." *Cachil Dehe Band*, 649 F. Supp. 2d at 1069–70 (quoting *United States v. Navarro*, 972 F.Supp. 1296, 1299 (E.D.Cal.1997), *rev'd on other grounds*, 160 F.3d 1254 (9th Cir. 1998) (internal quotation marks omitted)). "Ultimately, a party seeking reconsideration must show more than a disagreement with the Court's decision, and recapitulation of the cases and arguments considered by the court before rendering its original decision fails to carry the moving party's burden." *Id.* (quoting *United States v. Westlands Water Dist.*, 134 F. Supp. 2d 1111, 1131 (E.D.Cal. 2001). (internal quotation marks omitted)).

# 2. The Legislature and State Fail to Meet the Demanding Standard for Reconsideration in their Initial Briefing.

The Legislature and the State's motions fail to meet the demanding standard the Ninth Circuit has set for succeeding on reconsideration. In their original round of briefing on their motions to reconsider, the Legislature and the State do not identify an intervening change in controlling law or newly discovered evidence. Instead, they argue that this Court "committed clear error or made a decision that was manifestly unjust" when it granted the United States' motion for preliminary injunction. But then the Legislature and the State simply proceed in rehashing arguments previously presented or in making additional arguments that they could have raised earlier.

To the extent the Legislature and the State merely express their disagreement with the Court's decision and recapitulate the cases and arguments considered by the Court before rendering its initial decision, they have failed to carry their heavy burden on reconsideration. The Court will therefore deny their motions to reconsider on any of the grounds raised in their initial round of briefing. To the extent, however, the Idaho Supreme Court decision in *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132 (2023), somewhat altered the legal landscape since the Court issued its preliminary injunction, it merits some discussion.

# 3. The *Planned Parenthood* Decision Did Not Negate the Fundamental Principles Underpinning the Court's Preliminary Injunction.

In their supplemental briefing, the Legislature and the State suggests the Idaho Supreme Court's decision in *Planned Parenthood* amounts to an intervening change of controlling law, warranting reconsideration of the Court's preliminary injunction order.

They argue the Idaho Supreme Court "defined the scope of Idaho Code § 18-622 in at least two ways that conflict with this Court's interpretation of that law," upending this Court's analysis finding a conflict between the Total Abortion Ban and EMTALA. *See Id's Supp. Br.*, Dkt. 127. The Court disagrees.

In its preliminary injunction decision, the Court concluded that the Total Abortion Ban conflicts with EMTALA under principles of both impossibility and obstacle preemption. *August 24, 2022 Injunction*, pp. 19-34, Dkt. 95. First, the Court determined that, by virtue of the Total Abortion Ban's affirmative defense structure, "it is impossible to comply with both laws" because "federal law requires the provision of care and state law criminalizes that very care." *Id.* at 19. Second, this Court found that "the plain language of the statutes demonstrates that EMTALA requires abortions that the affirmative defense would not cover." *Id.* at 20. And third, this Court concluded that "Idaho's criminal abortion law will undoubtedly deter physicians from providing abortions in some emergency situations," which "would obviously frustrate Congress's intent to ensure adequate emergency care for all patients who turn up in Medicare-funded hospitals." *Id.* at 26.

In the *Planned Parenthood* decision, the Idaho Supreme Court confirmed that: (1) Idaho Code § 18-622 criminalizes *all* abortions, 522 P.3d at 1152 ("Unlike Idaho's historical abortion laws, which provided an exception to 'save' or 'preserve' the life of the woman, the Total Abortion Ban makes all 'abortions' a crime."); (2) the affirmative defense covers a narrower set of circumstances than those in which EMTALA requires a

hospital to offer stabilizing treatment, *id.* at 1196 (noting Idaho Code § 18-622 "does *not* include the broader 'medical emergency' exception for abortions" contained in Idaho Code § 18-8804(1)); and (3) a provider's invocation of the affirmative defense may still be challenged at trial, after the provider has been charged, arrested, and potentially detained, and thus will continue to deter the provision of medically necessary abortions, *id.* (noting "a physician who performed an "abortion' ...could be charged, arrested, and confined until trial *even if* the physician initially claims they did it to preserve the life of the mother....[and] "[o]nly later, at trial, would the physician be able to raise the affirmative defenses available in the Total Abortion Ban").

In other words, the Idaho Supreme Court's decision in *Planned Parenthood* confirms each of the fundamental principles that underpinned this Court's decision enjoining Idaho Code § 18-622 to the extent it conflicts with EMTALA; it therefore does not provide a basis for this Court to reconsider its decision. By contrast, the aspects of the Idaho Supreme Court's decision on which the State and Legislature focus—i.e., that the affirmative defense is subjective rather than objective, and that the Total Abortion Ban does not apply to ectopic or other nonviable pregnancies—do not fundamentally alter this Court's preemption analysis.

The Idaho Supreme Court held that the necessary-to-prevent-death affirmative defense "does not require *objective* certainty" nor "a particular level of immediacy" before the abortion can be "necessary" to prevent a pregnant woman's death. *Planned Parenthood*, 522 P.3d at 1203. Thus, according to the State, because the affirmative

Abortion Ban and EMTALA because the ban "does not require a 'medically impossible' determination that a pregnant woman is certain to die without an abortion," and neither does it promote delays or worsened patient outcomes by encouraging physicians to wait to provide care until a pregnant woman is nearer to death. *Id. Supp. Br.*, pp. 1-2, Dkt. 127.

First, this argument ignores – as the Idaho Supreme Court decision makes clear – that "the Total Abortion Ban makes all 'abortions' a crime," and "a physician who perform[s] an 'abortion'... [can] be charged, arrested, and confined until trial even if the physician initially claims they did it to preserve the life of the mother." *Planned* Parenthood, 522 P.3d at 78 (emphasis in original). "Only later, at trial, would the physician be able to raise the affirmative defenses available under the Total Abortion Ban...to argue it was a *justifiable* abortion that warrants acquittal and release." *Id.* This is true regardless of whether the affirmative defense is "subjective" or "objective." It also remains true that EMTALA requires physicians to offer medical care that state law criminalizes. Thus, the Idaho Supreme Court's decision, as consistent with this Court's holding, confirmed – rather than eliminated – the conflict between EMTALA and the Total Abortion Ban: Because "federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws" and the state law is preempted. August 24, 2022 Injunction, p. 19, Dkt. 95.

Second, this argument ignores a second key rationale undergirding this Court's preliminary injunction decision: the affirmative defense applies to a narrower scope of

conduct than EMTALA covers. August 24, 2022 Injunction, p. 20, Dkt. 95. A physician may only assert the affirmative defense at trial when "the abortion was necessary to prevent the death of the pregnant woman." I.C. § 18-622(3)(a)(ii). But EMTALA requires providing stabilizing care not just when the patient faces death, but also when a patient faces serious health risks that may stop short of death, including permanent and irreversible health risks and impairment of bodily functions. 42 U.S.C. § 1395dd(e)(1)(A). As the Court explained in its decision, the pregnant patient may face grave risks to her health, "such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, or hypoxic brain injury" – but if the pregnant patient does not face death, the ban's affirmative defense offers no protection to a physician who performs an abortion. August 24, 2022 Injunction, pp. 2-3, 20, Dkt. 95. The Idaho Supreme Court confirmed as much when it noted that the Total Abortion Ban "does not include the broader 'medical emergency' exception for abortions present in [another Idaho abortion statute]." Planned Parenthood, 522 P.3d at 1196. The lack of such an exception, or even affirmative defense, is yet another reason that a conflict exists between EMTALA and § 18-622. August 24, 2022 Injunction, p. 20, Dkt. 95. Again, the subjective nature of the affirmative defense does not change this result, given that the Planned Parenthood decision did not expand the scope of the defense to include health-threatening conditions.

Likewise, the Idaho Supreme Court's narrowing the scope of the Total Abortion

Ban to exclude ectopic and other "non-viable pregnancies" did not eliminate the conflict

between Idaho law and EMTALA. In *Planned Parenthood*, contrary to this Court's interpretation, the Idaho Supreme Court applied a "limiting judicial construction, consistent with apparent legislative intent" to conclude that § 18-622 does not "contemplate ectopic pregnancies" or other "non-viable pregnancies." *Id.* at 1202-1203. Both the State and the Legislature argue that this limiting construction eliminates any conflict between EMTALA and the Total Abortion Ban by pointing to the United States' examples involving ectopic pregnancies. *Leg. 's Supp. Br.*, p. 2, Dkt. 126, *Id. Supp. Br.*, pp. 7-8, Dkt. 127. But this Court's decision finding a conflict between § 18-622 and EMTALA did not rest on its conclusion that the ban encompasses ectopic pregnancies.

In its decision enjoining the Total Abortion Ban, this Court pointed to "many other complications," in addition to ectopic pregnancy, that "may place the patient's health in serious jeopardy or threaten bodily functions." *August 24, 2022 Injunction*, p. 8, Dkt. 95. As noted by the Court in its decision, "[s]ome examples include the following scenarios":

- A patient arrives at an emergency room with nausea and shortness of breath, leading to a diagnosis of preeclampsia. Preeclampsia can quickly progress to eclampsia, with the onset of seizures.
- A woman arrives at an emergency room with an infection after the amniotic sac surrounding the fetus has ruptured. That condition can progress into sepsis, at which point the patient's organs may fail.
- A patient arrives at the hospital with chest pain or shortness of breath, which leads the physician to discover elevated blood pressure or a blood clot.
- A patient arrives at the emergency room with vaginal bleeding caused by a placental abruption. Placental abruption is when the placenta partly or completely separates from the inner wall of the uterus. It can lead to catastrophic or uncontrollable bleeding. If the bleeding is uncontrollable, the patient may go into shock, which

could result in organ disfunction such as kidney failure, and even cardiac arrest

Id. at 8-9 (citing Fleisher Dec. ¶¶ 15-22, Dkt. 17-3). In each of these scenarios, the stabilizing care EMTALA requires a physician to offer may include terminating a-still developing pregnancy covered under the Idaho Supreme Court's more limited definition of "abortion." Thus, the exclusion of ectopic and other nonviable pregnancies from the Total Abortion Ban does not negate the continuing need to enjoin the ban to the extent it still clearly conflicts with EMTALA.

In short, the Court finds no reason to reconsider its decision granting the United States' motion for a preliminary injunction, and the injunction stands. To contest the preliminary injunction, the State and the Legislature may appeal and seek remedy with the Ninth Circuit. *Whittaker Corp. v. Execuair Corp.*, 953 F.2d 510, 515 (9th Cir. 1992) ("So I'm going to deny your motion and let's let the law lords of the Ninth Circuit reach a judgment.").

#### **ORDER**

#### IT IS ORDERED that:

- The Idaho Legislature's Motion for Reconsideration of Order Granting Preliminary Injunction (Dkt. 97) is **DENIED**.
- The State of Idaho's Motion to Reconsider Preliminary Injunction (Dkt. 101) is **DENIED.**

DATED: May 4, 2023

B. Lynn Winmill

U.S. District Court Judge

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-00329-BLW
MEMORANDUM DECISION AND
ORDER

#### INTRODUCTION

Pregnant women in Idaho routinely arrive at emergency rooms experiencing severe complications. The patient might be spiking a fever, experiencing uterine cramping and chills, contractions, shortness of breath, or significant vaginal bleeding. The ER physician may diagnose her with, among other possibilities, traumatic placental abruption, preeclampsia, or a preterm premature rupture of the membranes. In those situations, the physician may be called upon to make complex, difficult decisions in a fast-moving, chaotic environment. She may conclude that the only way to prevent serious harm to the patient or save her life is to terminate the pregnancy—a devastating result for the doctor and the patient.

So the job is difficult enough as it is. But once Idaho Code § 18-622 goes into effect, the physician may well find herself facing the impossible task of

attempting to simultaneously comply with both federal and state law. A decadesold federal law known as the Emergency Medical Treatment and Labor Act (EMTALA) requires that ER physicians at hospitals receiving Medicare funds offer stabilizing treatment to patients who arrive with emergency medical conditions. But when the stabilizing treatment is an abortion, offering that care is a crime under Idaho Code § 18-622—which bans all abortions. If the physician provides the abortion, she faces indictment, arrest, pretrial detention, loss of her medical license, a trial on felony charges, and at least two years in prison. Yet if the physician does not perform the abortion, the pregnant patient faces grave risks to her health—such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, hypoxic brain injury, or even death. And this woman, if she lives, potentially may have to live the remainder of her life with significant disabilities and chronic medical conditions as a result of her pregnancy complication. All because Idaho law prohibited the physician from performing the abortion.

Granted, the Idaho statute offers the physician the cold comfort of a narrow affirmative defense to avoid conviction. But only if she convinces a jury that, in her good faith medical judgment, performing the abortion was "necessary to prevent the death of the pregnant woman" can she possibly avoid conviction. Even then, there is no certainty a jury will acquit. And the physician cannot enjoy the

benefit of this affirmative defense if she performed the abortion merely to prevent serious harm to the patient, rather than to save her life.

Back to the pregnant patient in the emergency department. The doctor believes her EMTALA obligations require her to offer that abortion right now. But she also knows that all abortions are banned in Idaho. She thus finds herself on the horns of a dilemma. Which law should she violate?

Fortunately, the drafters of our Constitution had the wisdom to provide a clear answer in Article VI, Paragraph 2 of the Constitution—the Supremacy Clause. At its core, the Supremacy Clause says state law must yield to federal law when it's impossible to comply with both. And that's all this case is about. It's not about the bygone constitutional right to an abortion. This Court is not grappling with that larger, more profound question. Rather, the Court is called upon to address a far more modest issue—whether Idaho's criminal abortion statute conflicts with a small but important corner of federal legislation. It does.

As such, the United States has shown it will likely succeed on the merits. Given that—and for the reasons discussed in more detail below—the Court has determined it should preserve the status quo while the parties litigate this matter. The Court will therefore grant the United States' motion. During the pendency of this lawsuit, the State of Idaho will be enjoined from enforcing Idaho Code § 18-622 to the extent that statute conflicts with EMTALA-mandated care.

#### **BACKGROUND**

## A. The Emergency Medical Treatment and Labor Act

Congress enacted EMTALA in 1986 with the overarching purpose of ensuring that all patients receive adequate emergency medical care—regardless of the patient's ability to pay and regardless of whether the patient qualifies for Medicare. *See Arrington v. Wong,* 237 F.3d 1066, 1073-74 (9th Cir. 2001) (citation omitted). Under that Act, when a patient arrives at an emergency department and requests treatment, the hospital must provide an appropriate screening examination "to determine whether or not an emergency condition" exists. 42 U.S.C. § 1395dd(a). An "emergency medical condition" is defined to include:

- (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
  - (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). If a hospital determines that a patient has an

result in—

<sup>&</sup>lt;sup>1</sup> Sub-part (B) defines an emergency medical condition as it relates to "a pregnant woman having contractions," but that subsection is not relevant to the issues before the Court.

emergency medical condition, it must examine the patient and provide stabilizing treatment at the hospital, although a transfer is permitted under certain circumstances. 42 U.S.C. § 1395dd(b)(1). Under EMTALA, stabilizing an emergency medical condition generally means providing medical treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during" a discharge or transfer to another facility. 42 U.S.C. § 1395dd(e).

EMTALA applies to every hospital that has an emergency department and participates in Medicare. *See* 42 U.S.C. § 1395cc(a)(1)(I). And a participating hospital that fails to comply with EMTALA's screening requirement, stabilizing treatment, or transfer provisions may be subject to civil monetary penalties up to \$119,942 per violation. 42 U.S.C. § 1395dd(d)(1)-(2); 42 C.F.R. §1003.500 (2017). Likewise, treating physicians who violate EMTALA face civil monetary penalties of up to \$119,942 per violation and exclusion from Medicare and state health care programs. 42 U.S.C. § 1395dd(d)(1); 42 C.F.R. §1003.500.

# B. Idaho's Criminal Abortion Law<sup>2</sup>

Idaho Code § 18-622 is set to take effect on August 25, 2022. It provides

<sup>&</sup>lt;sup>2</sup> Idaho has enacted a series of statutes criminalizing abortion. The statute at issue here—and referred to at times as the "criminal abortion law" or the "Total Abortion Ban"—is codified (Continued)

that "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion." Idaho Code § 18-622(2). Abortion is defined as "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." § 18-604(1). Pregnancy, in turn, is defined as "the reproductive condition of having a developing fetus in the body and commences at fertilization." § 18-604(11).

Criminal abortion is a felony punishable by at least two, and up to five, years' imprisonment. § 18-622(2). In addition, "any health care professional who performs or attempts to perform or who assists in performing or attempting to perform an abortion" faces professional licensure suspension for a minimum of six months upon a first offense and permanent revocation for subsequent offenses. *Id*.

The statute provides two affirmative defenses. As relevant here, an accused physician may avoid conviction by proving, by a preponderance of the evidence, that:

(1) 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; and

at Idaho Code § 18-622. Not at issue is the later-enacted *Fetal Heartbeat Preborn Child Protection Act*, codified at Idaho Code § 18-8801 to 18-8808. According to Idaho Code § 18-8805, if Idaho Code § 18-622 becomes enforceable, the penalties specified in the Heartbeat Act will be superseded by §18-622. *See* Idaho Code § 18-8805(4).

(2) 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.

Idaho Code § 18-622(3)(a)(ii) and (iii).

#### C. Facts

Idaho has roughly 22,000 births per year. Not surprisingly then, some patients will experience serious, pregnancy-related complications that qualify as an "emergency medical condition" under EMTALA. *See generally Fleisher Dec.* ¶ 12, Dkt. 17-3; *Corrigan Dec.* ¶¶ 9-30, Dkt. 17-6; *Cooper Dec.* ¶¶ 6-12, Dkt. 17-7; *Seyb Dec.* ¶¶ 4-13, Dkt. 17-8.

One relatively straightforward example is a patient who presents at an emergency department with an ectopic pregnancy. *Id.* ¶ 13. Accounting for about 2% of all reported pregnancies, ectopic pregnancies occur when an embryo or fetus grows outside of the uterus, most frequently in a fallopian tube. *Ex. B. to Fleisher Dec.*, Dkt. 17-4, at 91. It is undisputed that an ectopic pregnancy in a fallopian tube is an emergency medical condition that places the patient's life in jeopardy. Left untreated it will cause the fallopian tube to rupture and, in the majority of cases, cause significant and potentially fatal internal bleeding. *See, e.g., White Dec.* ¶ 3, Dkt. 66-1. Likewise, the parties do not dispute that the appropriate treatment for an MEMORANDUM DECISION AND ORDER - 7

ectopic pregnancy is either "emergency surgery and removal of the involved fallopian tube, including the embryo or fetus, or administration of a drug to cause embryonic or fetal demise." *Fleisher Dec.* ¶ 13, Dkt. 17-3. Still, though, during oral argument, the State conceded that the procedure necessary to terminate an ectopic pregnancy is a criminal act, given the broad definitions used in Idaho's criminal abortion statute.

In addition to ectopic pregnancies, there are many other complications that may arise during pregnancy—all of which may place the patient's health in serious jeopardy or threaten bodily functions. Despite the risks such conditions present, it is not always possible for a physician to know whether treatment for any particular condition, at any particular moment in time, is "necessary to prevent the death" of the pregnant patient, which is the prerequisite to their relying on the affirmative defense offered by the criminal abortion statute. *See Fleisher Dec.* ¶¶ 13-21, Dkt. 17-3. Some examples include the following scenarios:

- A patient arrives at an emergency room with nausea and shortness of breath, leading to a diagnosis of preeclampsia.
   Preeclampsia can quickly progress to eclampsia, with the onset of seizures.
- A woman arrives at an emergency room with an infection after the amniotic sac surrounding the fetus has ruptured. That condition can progress into sepsis, at which point the patient's organs may fail.
- A patient arrives at the hospital with chest pain or shortness of breath, which leads the physician to discover elevated blood

pressure or a blood clot.

• A patient arrives at the emergency room with vaginal bleeding caused by a placental abruption. Placental abruption is when the placenta partly or completely separates from the inner wall of the uterus. It can lead to catastrophic or uncontrollable bleeding. If the bleeding is uncontrollable, the patient may go into shock, which could result in organ disfunction such as kidney failure, and even cardiac arrest.

*Id.* ¶¶ 15-22.

Idaho physicians have submitted declarations describing specific patients who have presented with these types of complications and have required abortions.<sup>3</sup> Each of these conditions unquestionably qualifies as an "emergency medical condition" under EMTALA. Accordingly, if future patients with similar conditions presented at Medicare-funded hospitals, they would be entitled to the emergency care required by EMTALA—which will often include an emergency abortion.

The impact of Idaho's criminal abortion statute on the emergency care

<sup>&</sup>lt;sup>3</sup> See Corrigan Dec. ¶¶ 9-30, Dkt. 17-6 (describing three patients who required abortions after experiencing, respectively, (1) severe infection due to premature rupture of the membranes; (2) placental abruption which other medications and blood products failed to mitigate; and (3) preeclampsia with pleural effusions and high blood pressure); Cooper Dec. ¶¶ 6-11, Dkt. 17-7 (describing three patients who required abortions after experiencing, respectively, (1) preeclampsia with severe features, (2) HELLP syndrome, and (3) lab abnormalities consistent with a diagnosis of HELLP syndrome); Seyb Dec. ¶¶ 7-13, Dkt. 17-8 (describing three patients who required abortions after experiencing, respectively, (1) a septic abortion, (2) preeclampsia with severe features, and (3) heavy vaginal bleeding).

dictated by EMTALA is substantial. The United States has submitted declarations from four physicians practicing in Idaho who say that if Idaho Code § 18-622 goes into effect, they believe "there will be serious and negative consequences for patients and healthcare workers alike." Corrigan Supp. Dec. ¶ 13, Dkt. 86-3. Dr. Emily Corrigan, a board-certified Obstetrician-Gynecologist practicing at a Boise hospital, explains why this is so. First, she speaks specifically as to three recent patients—all of whom presented with emergency medical conditions and required an abortion. She says that for each of these patients, it was "medically impossible to say that death was the guaranteed outcome." Id. ¶ 8. Regarding Jane Doe 1, for example, she says that this patient "could have developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but [she] could still be alive." *Id.* Jane Does 2 and 3 were in similar situations—they could have survived, but each "potentially would have had to live the remainder of their lives with significant disabilities and chronic medical conditions as a result of their pregnancy complication." Id..

More broadly, Dr. Corrigan says that "while the State's physician declarations speak in terms of absolutes," in her view, "medicine does not work that way in most cases. Death may be a possible or even probable outcome, but different outcomes or conditions may also be probable. That is why doctors

frequently refuse to answer the question, 'What are my chances?'" Id. ¶ 9.

Dr. Corrigan also points out that if Idaho Code § 18-622 goes into effect, patient care will be delayed. *Id.* ¶ 11. She says that, under Idaho's law, physicians must "wait until death is near-certain and in the meantime, the patient will experience pain and complications that may have lifelong disabling consequences." *Id.* Ultimately then, from her perspective, "[a] physician administering an emergency abortion in Idaho would be risking their professional license, livelihood, personal security, and freedom." *Id.* 

Compliance with the EMTALA standards is significant to this state's health care system. In Idaho, there are thirty-nine hospitals that receive Medicare funding and provide emergency services. *Wright Dec.* ¶ 8, Dkt. 17-9. Between 2018 and 2020, these hospitals' emergency departments received approximately \$74 million in federal Medicare funding, which was conditioned on compliance with EMTALA. *Shadle Dec.* ¶ 6, Dkt. 17-10.

#### LEGAL STANDARD

The United States asks for a preliminary injunction to enjoin Idaho from enforcing its criminal abortion law to the extent it conflicts with EMTALA-mandated care. "A preliminary injunction is 'an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of persuasion." Fraihat v. United States Immigration & Customs Enf't, 16

F.4th 613, 635 (9th Cir. 2021) (citation omitted).

To obtain relief, the United States must establish that: (1) it is likely to succeed on the merits; (2) it is likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in its favor; and (4) an injunction is in the public interest. *Winter v. NRDC*, 555 U.S. 7, 24 (2008). As to the last two factors, "[w]here the government is a party to a case in which a preliminary injunction is sought, the balance of the equities and public interest factors merge." *Padilla v. Immigration & Customs Enf't*, 953 F.3d 1134, 1141 (9th Cir. 2020).

"A district court has considerable discretion in granting injunctive relief and in tailoring its injunctive relief." *United States v. AMC Entm't, Inc.*, 549 F.3d 760, 768 (9th Cir. 2008). Generally, a court must ensure that the relief is "tailored to eliminate only the specific harm alleged" and not "overbroad." *E.&J. Gallo Winery v. Gallo Cattle Co.*, 967 F.2d 1280, 1297 (9th Cir. 1992). "[I]njunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). And in the context of enjoining a state statute subjected to an as-applied challenge, the Supreme Court has said, "Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem. We . . . enjoin only the unconstitutional applications of a statute while leaving other applications in force." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S.

320, 328-29 (2006).

#### **ANALYSIS**

The key substantive question this Court must address is whether Idaho Code § 18-622 conflicts with certain requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. But before turning to that question, the Court will resolve three threshold issues: (1) whether the United States has a cause of action; (2) whether the United States has standing; and (3) whether the United States has mounted a facial or an as-applied attack to the challenged statute.

#### A. Cause of Action

The United States has the unquestioned authority to sue. It has asked this Court, sitting in equity, to partially enjoin the enforcement of Idaho Code § 18-622 because of its direct conflict with a federal statute. Such a Supremacy Clause claim fits squarely within causes of action the Supreme Court has recognized. As the Supreme Court explained in *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question." *Id.* at 96 n.14; *see also Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 326 (2015) ("[W]e have long recognized, if an individual claims federal law immunizes him

from state regulation, the court may issue an injunction upon finding the state regulatory actions preempted."). Here, the United States has a cause of action because it seeks to halt Idaho's allegedly unconstitutional encroachment on EMTALA; it is not seeking to enforce federal law against would-be violators. This case is therefore distinct from the line of cases where plaintiffs challenge state administrative action taken under a particular statute, as opposed to challenging the validity of the state statute itself. *See*, *e.g.*, *Armstrong*, 575 U.S. at 324.

In a somewhat related argument, the State, in its briefing, attempted to raise[] serious concerns that EMTALA's required stabilizing treatment, as interpreted by the United States and expressed in this litigation, is invalid as coercive spending clause legislation." State Br., Dkt. 66, at 19 n.10 (citing Nat'l Fed. of Indep. Bus. v. Sebelius, 567 U.S. 519, 575-87 (2012)). To the extent this "concern" is an argument, it is not sufficiently developed here. Cf. Indep. Towers of Wash. v. Washington, 350 F.3d 925, 930 (9th Cir. 2003) ("We require contentions to be accompanied by reasons."). The State cannot challenge the constitutionality of a 35-year-old federal statute in a passing footnote. More importantly, deciding that question would "run contrary to the fundamental principle of judicial restraint that courts should neither 'anticipate a question of constitutional law in advance of the necessity of deciding it' nor 'formulate a rule of constitutional law broader than is required by the precise

facts to which it is to be applied." Wash. State Grange v. Wash. State

Republican Party, 552 U.S. 442, 450 (2008) (quoting Ashwander v. TVA, 297

U.S. 288, 346-47 (1936) (Brandeis, J., concurring)).

### B. Standing

To establish standing, the United States must demonstrate that it has suffered an injury in fact that is fairly traceable to Idaho's actions and that will likely be redressed by a favorable decision from the Court. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).

Here, United States alleges at least three types of harm. First, the United States' sovereign interests are harmed when its laws are violated. *See Vt. Agency of Nat. Res. v. United States ex rel Stevens*, 529 U.S. 765, 771 (2000); *United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011), *rev'd in part on other grounds*, 567 U.S. 387 (2012). Second, if Idaho Code § 18-622 goes fully into effect, pregnant patients throughout Idaho will be denied EMTALA-mandated care. As a general principle, the United States may sue to redress widespread injuries to the general welfare. *In re Debs*, 158 U.S. 564, 584 (1895). Third, the United States has alleged that Idaho's law deprives it of the benefits of its bargain in that it has provided Medicare funding to hospitals within Idaho, and that funding was conditioned on those hospitals' compliance with EMTALA.

From there, the standing analysis is simple. The harms the United States

alleges are traceable to Idaho's actions in enacting and, soon, enforcing Idaho

Code § 18-622. And the remedies sought here would redress the injury. The United

States thus has established standing.

### C. Facial versus As-Applied

"As a general matter, a facial challenge is a challenge to an entire legislative enactment or provision," *Hoye v. City of Oakland*, 653 F.3d 835, 857 (9th Cir. 2011), and a successful facial challenge "invalidates the law itself." *Italian Colors Restaurant v. Becerra*, 878 F.3d 1165, 1175 (9th Cir. 2018). An as-applied challenge, on the other hand, "challenges only one of the rules in a statute, a subset of the statute's applications, or the application of the statute to a specific circumstance." *Hoye*, 653 F.3d at 857. Thus, "a successful as-applied challenge invalidates only the particular application of the law." *Italian Colors*, 878 F.3d at 1175 (internal quotation and citation omitted).

Ultimately, though, "[t]he label is not what matters." *Doe v. Reed*, 561 U.S. 186, 194 (2010) (acknowledging that plaintiffs' claim had characteristics of both an as-applied and facial challenge). Rather, the "important" inquiry is whether the "claim and the relief that would follow . . . reach beyond the particular circumstances of the[] plaintiffs." *Id.* In other words, the distinction between the two types of challenges mainly goes to the breadth of the remedy.

Here, a quick skim of the United States' complaint reveals an as-applied

challenge. In its prayer for relief, the United States asks the Court to issue a declaratory judgment stating that "Idaho Code § 18-622 violates the Supremacy Clause and is preempted and therefore invalid *to the extent that it conflicts with EMTALA*." *Compl.* ¶ 16, Dkt. 1 (emphasis added). The complaint repeats that limiting language in the prayer for injunctive relief. *Id.* And in moving for a preliminary junction, the United States once again—and repeatedly—clarified that it is seeking a limited form or relief. *See, e.g., Mtn.*, Dkt. 17-1, at 8.

The State acknowledges this limiting language but nevertheless argues that the United States is bringing a facial challenge, based on the United States' argument that there is a conflict in *all* instances in which both EMTALA and Idaho Code § 18-622 apply. The State says this isn't so because, at times, the two statutes can operate harmoniously.

The Court does not find the State's argument persuasive because it has failed to properly account for the staggeringly broad scope of its law, which has been accurately characterized by this Court and the Idaho Supreme Court as a "Total Abortion Ban." *See Planned Parenthood Great Nw. v. Idaho*, --- P.3d ---, 2022 WL 3335696, at \*1 (Idaho Aug. 12, 2022). As will be discussed more fully below, Idaho Code § 18-622 doesn't just criminalize EMTALA-mandated abortions; it criminalizes all abortions. So, in that sense, the United States has mounted a textbook, as-applied challenge focusing only on a particular application of the

statute in a particular context. After all, Idaho Code § 18-622 will take effect on August 25, 2022, regardless. The United States is not trying to stop that. The only question this Court is addressing is whether the statute must include a carve-out for EMTALA-mandated care. The United States has mounted an as-applied challenge.

Moreover, even if the Court were to construe the challenge as a facial one—focusing only on the subset of abortions EMTALA requires—the United States is still likely to succeed on the merits of its claim. As explained below, even within that subset there will always be a conflict between EMTALA and Idaho Code § 18-622.

#### D. Likelihood of Success on the Merits

With these threshold questions resolved, the Court turns to whether the United States is entitled to a preliminary injunction. The first question—whether the United States is likely to succeed on the merits—is the most important.

California v. Azar, 950 F.3d 1067, 1083 (9th Cir. 2020). To resolve that question, the Court is guided by the Supremacy Clause and basic preemption principles.

## 1. The Supremacy Clause & Preemption

The Supremacy Clause provides that federal law "shall be the supreme Law of the Land." U.S. Const. art. VI, cl. 2. "Congress may consequently pre-empt, *i.e.*, invalidate, a state law through federal legislation." *Oneok, Inc. v. Learjet, Inc.*, 575 U.S. 373, 376 (2015).

In EMTALA, Congress indicated its intent to displace state law through an express preemption provision, which says EMTALA preempts state law only "to the extent that the [state law] requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). The Ninth Circuit has construed EMTALA's "directly conflicts" language as referring to two types of preemption—impossibility preemption and obstacle preemption. *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993). Impossibility preemption occurs, straightforwardly, "where it is impossible for a private party to comply with both state and federal law." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000). And obstacle preemption exists where state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 373.

## 2. Impossibility Preemption

Here, it is impossible to comply with both statutes. As already discussed, when pregnant women come to a Medicare-funded hospital with an emergency medical condition, EMTALA obligates the treating physician to provide stabilizing treatment, including abortion care. But regardless of the pregnant patient's condition, Idaho statutory law makes that treatment a crime. Idaho Code § 18-622(2). And where federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws. Full stop.

The statute's affirmative defense does not cure the impossibility. An affirmative defense is an excuse, not an exception. The difference is not academic. The affirmative defense admits that the physician committed a crime but asserts that the crime was justified and is therefore legally blameless. And it can only be raised after the physician has already faced indictment, arrest, pretrial detention, and trial for every abortion they perform. *See generally United States v. Sisson*, 399 U.S. 267, 288 (1970) (indictments need not anticipate affirmative defenses). So even though accused healthcare workers might avoid a conviction, the statute still makes it impossible to provide an abortion without also committing a crime.

Moreover, even taking the affirmative defense into account, the plain language of the statutes demonstrates that EMTALA requires abortions that the affirmative defense would not cover. When an abortion is the necessary stabilizing treatment, EMTALA directs physicians to provide that care if they reasonably expect the patient's condition will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious jeopardy to the patient's health. 42 U.S.C. § 1395dd(3)(1). In contrast, the criminal abortion statute admits to no such exception. It only justifies abortions that the treating physician determines are *necessary* to prevent the patient's death. Idaho Code § 18-622(a)(ii) (emphasis added). According to the dictionary, the word "necessary" means something is "needed" or "essential." *See Necessary*, Black's Law Dictionary

(11th ed. 2019). And the Idaho Supreme Court has said that "[w]hen engaging in statutory interpretation," it "begins with the dictionary definitions of disputed words or phrases contained in the statute." *Idaho v. Clark*, 484 P.3d 187, 192 (Idaho 2021). Thus, an abortion is only justified under the statute if the treating physician can persuade the jury that she made a good faith determination that the patient would have died if the abortion had not been performed.

EMTALA is thus broader than the affirmative defense on two levels. First, it demands abortion care to prevent injuries that are more wide-ranging than death. Second, and more significantly, it calls for stabilizing treatment, which of course may include abortion care—when harm is probable, when the patient could "reasonably be expected" to suffer injury. In contrast, to qualify for the affirmative defense, the patient's death must be imminent or certain absent an abortion. It is not enough, as the Legislature has argued, for a condition to be life-threatening, which suggests only the *possibility* of death. *See Life-Threatening*, Black's Law Dictionary (11th ed. 2019) ("illness, injury, or danger that *could* cause a person to die") (emphasis added).

Finally, as the Court discusses further below, when the defense is put up against the realities of medical judgments, its scope is tremendously ambiguous. Although this makes it difficult to determine whether some abortions would qualify for both the affirmative defense and be mandated by EMTALA, that

question is ultimately immaterial to the Court's determination that it is impossible for physicians to comply with both statutes.

Seeking to skirt the conflict between federal and state law, the Legislature advances three main points. First, the Legislature submits declarations from two physicians who offer up opinions as to what Idaho Code § 18-622 means. They say that terminating a pregnancy to save the life of the pregnant woman is never considered an abortion under Idaho law. French Dec. ¶¶ 14, 17, Dkt. 71-5; Reynolds Dec. ¶ 12, Dkt. 71-1. But as already discussed, on its face, the Idaho law criminalizes all procedures intended to terminate a pregnancy, even if necessary to save the patient's life or to preserve her health. See Idaho Code § 18-604(1). And it should go without saying that Idaho law controls the inquiry on this point—not the medical community. Indeed, if anything, this argument crystallizes the conflict between Idaho law and EMTALA: Idaho law criminalizes as an "abortion" what physicians in emergency medicine have long understood as both life- and healthpreserving care.

The Legislature's primary example of ectopic pregnancies as falling outside the statutory prohibition further reveals the fallacy of their argument: Idaho law expressly defines "pregnancy" as "having a developing fetus in the body" and commencing at fertilization. Idaho Code § 18-604(11). This plain language, which refers to "the body," rather than the uterus, and "fertilization" rather than

implantation, evinces the Legislature's intent to include ectopic pregnancies within the statutory definition of "pregnancy." *See Worley Highway Dist. v. Kootenai Cnty.*, 576 P.2d 206, 209 (Idaho 1978). As such, termination of an ectopic pregnancy falls within the definition of an "abortion." The Legislature cannot avoid the effect of its chosen statutory language by relying on the medical community's definition of what is (and what is not) an abortion.

The Legislature next says that terminations of ectopic pregnancies—or any other, similar lifesaving procedures—do not fall within the scope of the statute because such terminations are "covered" by the exemption of Idaho Code § 18-622(4). See French Dec. ¶ 15, Dkt. 71-5. This sub-section exempts from the statute's prohibitions medical treatment provided to pregnant women that results in the "accidental death" or "unintentional injury" to the fetus. Idaho Code § 18-622(4). But certain pregnancy-related conditions, such as ectopic pregnancy, require pregnancy termination to preserve a patient's health or save her life—and the "death" or "injury" to the "unborn child" in that situation will be neither accidental nor unintentional. See Cooper Dec. ¶ 3, Dkt. 17-6; Fleisher Dec. ¶ 13, Dkt. 17-3; Seyb Dec. ¶ 6, Dkt. 17-8. It is therefore nonsensical to classify it as such, simply because the pregnancy was terminated to save the life or health of the mother.

Second, during oral argument, the Legislature acknowledged the

"conceptual textual conflicts" between § 18-622 and EMTALA but entreated the Court to ignore the Idaho statute's text and focus instead on "what happens in the real world." Even if the Court accepted this invitation to ignore what the law says, the Legislature's speculations about how the law will work in practice are belied by the actual, "real-life" experience of medical professionals in Idaho who regularly treat women in these situations. They conclude that emergency care normally provided to pregnant patients will be made criminal by the plain language of § 18-622, which will, in turn, hinder their ability to provide that care if the law goes into effect. See Corrigan Dec. ¶¶ 31-35, Dkt. 17-6; Cooper Dec. ¶ 12, Dkt. 17-7; Seyb Dec. ¶ 13, Dkt. 17-8. As one Idaho physician testified, OB/GYN physicians in Idaho have been "bracing for the impact of this law, as if it is a large meteor headed towards Idaho." Supp. Cooper Dec. ¶ 13, Dkt. 86-3. More fundamentally, if the law does not mean what it says, why have it at all?

In short, given the extraordinarily broad scope of Idaho Code § 18-622, neither the State nor the Legislature have convinced the Court that it is possible for healthcare workers to simultaneously comply with their obligations under EMTALA and Idaho statutory law. The state law must therefore yield to federal law to the extent of that conflict.

## 3. Obstacle Preemption

Moreover, even if it were theoretically possible to simultaneously comply

with both laws, Idaho law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Crosby*, 530 U.S. at 373. To be sure, the Supreme Court has cautioned that "a high threshold must be met if a state law is to be pre-empted for conflicting with the purposes of a federal Act." *Chamber of Commerce of the United States v. Whiting*, 563 U.S. 582, 607 (2011) (citation and quotation omitted). Nevertheless, that threshold is met when it is plain that "Congress made 'a considered judgment' or 'a deliberate choice' to preclude state regulation" because "a federal enactment clearly struck a particular balance of interests that would be disturbed or impeded by state regulation." *In re Volkswagen "Clean Diesel" Mktg., Sales Practices, & Prods. Liab. Litig.*, 959 F.3d 1201, 1212 (9th Cir. 2020) (*quoting Arizona*, 567 U.S. at 405).

"The first step in the obstacle preemption analysis is to establish what precisely were the purposes and objectives of Congress in enacting" the statute at issue. *Chamber of Commerce v. Bonta*, 13 F.4th 766, 778 (9th Cir. 2021). For nearly four decades, EMTALA has served as the bedrock for the emergency-care safety net. Congress enacted EMTALA primarily because it was "concerned that medically unstable patients are not being treated appropriately" including in "situations where treatment was simply not provided." H.R. Rep. No. 99-241, Pt. I, at 27 (1985). Congress's clear purpose was to establish a bare minimum of emergency care that would be available to all people in Medicare-funded hospitals.

See Arrington v. Wong, 237 F.3d 1066, 1073-74 (9th Cir. 2001).

Congress chose to use "federal sanctions" to ensure that emergency screening and treatment was available for "all individuals for whom care is sought." H.R. Rep. No. 99-241, Pt. III, at 4-5 (1985). But Congress was mindful that overly severe sanctions might lead "some hospitals, particularly those located in rural or poor areas, [to] decide to close their emergency rooms entirely rather than risk the . . . penalties that might ensue." *Id.* at 6. Notably, Congress took care to avoid sanctions that would "result in a decrease in available emergency care, rather than an increase in such care, which appears to have been the major goal of [EMTALA]." *Id.* 

Here, Idaho's criminal abortion statute, as currently drafted, stands as a clear obstacle to what Congress was attempting to accomplish with EMTALA. As discussed below, Idaho's criminal abortion law will undoubtedly deter physicians from providing abortions in some emergency situations. That, in turn, would obviously frustrate Congress's intent to ensure adequate emergency care for all patients who turn up in Medicare-funded hospitals.

## a. Idaho Code § 18-622 Deters Abortions

It goes without saying that all criminal laws have some deterrent effect. But the structure of Idaho's criminal abortion law—specifically that it provides for an affirmative defense rather than an exception—compounds the deterrent effect and

increases the obstacle it poses to achieving the goals of EMTALA.

For one, the process of enduring criminal prosecution and licensing authority sanctions has a deterrent effect, regardless of the outcome. As Dr. Corrigan aptly explained, "[h]aving to defend against such a case would be incredibly burdensome, stressful, costly." *Corrigan Dec.* ¶ 10, Dkt. 17-6. By criminalizing all abortions, Idaho guarantees that physicians will have to accept this hardship every time they perform an abortion. The result is reluctance to perform abortions in any circumstances.

The uncertain scope of the affirmative defense intensifies that result.

Providers who might be willing to depend on the affirmative defense do not have the clarity to do so because of the statute's ambiguous language and the complex realities of medical judgments.

Consider what a defendant-physician needs to prove to avail herself of the affirmative defense. The core of the affirmative defense at issue requires the defendant-physician to show she determined "the abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2). In that sense, the defense is objective—either the defendant-physician made the determination, or she did not. Yet the nature of that determination—how imminent a patient's death must before an abortion is necessary—is inscrutable.

Applying the standard to another medical context shows its ambiguity. Say a

sovereign adopted a law that allowed oncologists to provide cancer treatment "only when necessary to prevent death." Under that standard, oncologists would likely feel comfortable providing care to a patient with a stage four terminal cancer diagnosis. But what about a patient with stage one cancer? On the one hand, treatment may be lawful because the patient has a condition that, left untreated, will eventually, almost certainly cause death. On the other hand, the patient is not in danger of dying soon, so perhaps the oncologist needs to withhold treatment until the cancer progresses to the point where treatment is more obviously necessary to prevent death.

Idaho physicians treating pregnant women face this precise dilemma. As Dr. Cooper puts it, "For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense." *See Cooper Supp. Dec.* ¶ 2, Dkt. 86-5. In other words, when, precisely, does the "necessary-to-prevent-death" language apply? Healthcare providers can seldom know the imminency of death because medicine rarely works in absolutes. *Corrigan Supp. Dec.* ¶ 9, Dkt. 86-3. Instead, physicians treat patients whose medical risks "exist along a continuum" without bright lines to specify "when exactly a condition becomes 'life-threatening' or 'necessary to prevent the death'

of the pregnant patient." Fleisher Supp. Dec. ¶ 7, Dkt. 86-2; see also Seyb Dec. ¶ 13, Dkt. 17-8 (explaining that "prevent the death of the pregnant woman" standard is not useful because "this is not a dichotomous variable"). Faced with these limitations, physicians provide care by making "educated guess[es] . . . . [b]ut we can only rarely predict with certainty a particular outcome." Corrigan Supp. Dec. ¶ 9, Dkt. 86-3. Because medical needs present on a spectrum, in a given moment of decision, "[d]eath may be a possible or even probable outcome, but different outcomes may also be possible or probable." Id.

But the affirmative defense is only available to physicians once they make that often "medically impossible" determination that "death [i]s the guaranteed outcome." *Corrigan Supp. Dec.* ¶ 8; *see also ACEP et al Amicus Br.*, Dkt. 62 at 6 (describing the affirmative defense as "a legislatively imagined but medically nonexistent line"); *Fleisher Dec.* ¶ 12, Dkt. 17-3 ("[I]n some cases where the patient's health is unambiguously threatened, it may be less clear whether there is also a certainty of death without stabilizing treatment—and a physician may not ever be able to confirm whether death would result absent immediate treatment.").

In short, against the backdrop of these uncertain, medically complex situations, the affirmative defense is an empty promise—it does not provide any clarity. The upshot of this uncertainty is that even those providers willing to risk prosecution if they were confident in the availability of the affirmative defense will

be deterred from providing emergency abortion care under EMTALA, where the availability of the defense is so uncertain.

And the Legislature cannot step in and say there is no obstacle to providing EMTALA-mandated care—that these Idaho healthcare workers may comfortably forge ahead and provided emergency abortions—based on its assertion that Idaho prosecutors would not enforce the law as written.<sup>4</sup> The Legislature supports this argument with a single declaration from a single county prosecutor, who said he "would not prosecute any health care professional based on facts like those set forth in [the United States'] declarations, and that he "believe[s] no Idaho prosecuting attorney would do so." Loebs Dec. ¶ 7, Dkt. 71-6. But Idaho prosecutors have a statutory duty "to prosecute all felony criminal actions." Idaho Code § 31-2604(2) (emphasis added). And this one prosecutor lacks the authority to bind the other forty-three elected county prosecutors, let alone grand juries or citizens who might independently seek to initiate criminal proceedings, or any of the disciplinary boards that might pursue license revocation proceedings. Cf. Idaho

<sup>&</sup>lt;sup>4</sup> The Legislature also submitted a declaration from a Nevada doctor who opines that the standard laid out in Idaho Code § 18-622 "provides a clear and workable standard" and that "physicians may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors." *Reynolds Dec.* ¶¶ 9-10, Dkt. 71-1. The Court does not find this assertion persuasive. At best, it's a difference of opinion—some doctors will be chilled; some won't. On balance, and based on the factual record before it, the Court finds that if Idaho Code §18-622 goes into effect, physicians practicing in Idaho are likely to be deterred from providing EMTALA-mandated care, including emergency abortions.

Code § 19-1108 (grand juries); *Idaho v. Murphy*, 584 P.2d 1236, 1241 (Idaho 1978) (citizen complaints); § 18-622(2).

One prosecutor's promise to refrain from enforcing the law as written, therefore, offers little solace to physicians attempting to navigate their way around both EMTALA and Idaho's criminal abortion laws—and whose "professional license, livelihood, personal security, and freedom" are on the line. Corrigan Supp. Dec. ¶ 11, Dkt. 86-3 ("Our malpractice insurance may not cover us for performing an act that some may view as a crime."). Indeed, the Ninth Circuit has expressly rejected the argument that courts may uphold a law merely because the enacting authority promises to enforce it only to the extent it is consistent with federal law. United States v. City of Arcata, 629 F.3d 986, 992 (9th Cir. 2010) (holding officials' "promise of self-restraint does not affect our consideration of the ordinances' validity" under preemption doctrine). Physicians performing health- or life-saving abortions should not be left to "the mercy of noblesse oblige." Powell's Books, Inc. v. Kroger, 622 F.3d 1202, 1215 (9th Cir. 2010) (citation omitted) ("We may not uphold the statutes merely because the state promises to treat them as properly limited.").

## b. Deterring Abortions is an Obstacle to EMTALA

The clear and intended effect of Idaho's criminal abortion law is to curb abortion as a form of medical care. This extends to emergency situations,

obstructing EMTALA's purpose. Idaho's choice to impose severe and sweeping sanctions that decrease the overall availability of emergency abortion care flies in the face of Congress's deliberate decision to do the opposite.

The primary obstacle is delayed care. Under the status quo, physicians "rely upon their medical judgement or best practices for handling pregnancy complications." *Seyb Dec.* ¶ 13, Dkt. 17-8. But because of the criminal abortion statute, "providers will likely delay care for fear of criminal prosecution and loss of licensure." *Id.; see also Cooper Supp. Dec.* ¶ 7, Dkt. 86-5 ("provider fear and unease is real and widespread"). The incentive to do so is obvious—delaying care so that the patient gets nearer to death and thus closer to the blurry line of the affirmative defense. Providers may also delay care to allow extra time to consult with legal experts. *See, e.g., Corrigan Dec.* ¶¶ 25, Dkt. 17-6.

Delayed care is worse care. "The goal in medicine is to effectively identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. *See Huntsberger Dec.* ¶ 12, Dkt. 86-4. Rather than providing the stabilizing treatment that EMTALA calls for, Idaho subjects women in medical crisis to periods of "serious physical and emotional trauma" as they wait to get nearer and nearer to death. *Corrigan Supp. Dec.* ¶ 13, Dkt. 86-3.

The wait for care is troubling enough on its own. Even worse, delayed care worsens patient outcomes. As a result of delay, "[p]atients may experience serious complications, have negative impacts on future fertility, require additional hospital resources including blood products, and some patients may die." *Huntsberger Dec.* ¶ 15, Dkt. 86-4. A recent study of maternal morbidity in Texas confirms this. When a pregnant woman with specific pregnancy complications was treated with "the standard protocol of terminating the pregnancy to preserve the pregnant patient's life or health," the rate of serious maternal morbidity was 33 percent. *California et al Amicus Br.*, Dkt. 59 at 21.5 That rate reached 57 percent, nearly doubling, when providers used "an expectant-management approach," meaning the physician provided "observation-only care until serious infection develops or the fetus no longer has cardiac activity." *Id.* 

These delays in providing care frustrate EMTALA in two ways. First, delays frustrate Congress's intent to eliminate situations where treatment was simply not provided by providing for basic emergency treatment. Second, the worsened patient outcomes offend EMTALA's core purpose of ensuring that the most vulnerable people were not left to suffer catastrophic outcomes because of

<sup>&</sup>lt;sup>5</sup> Citing Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, Am. J. Obstetrics & Gynecology (forthcoming 2022) (internet).

indifference from physicians—or, in this case, obstacles created by the State.

Another effect of Idaho's criminal abortion law is that it will likely make it more difficult to recruit OB/GYNs, who are on the front lines of providing abortion care in emergency situations. Because Idaho does not have in-state training for the specialty, all OB/GYNs must be recruited to come here. *Seyb Dec.* ¶ 14, Dkt. 17-8. But if these newly trained physicians "can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here." *Id.* By extension, OB/GYNs who are already practicing here may choose to leave or to change the nature of their practice. *See, e.g., Corrigan Dec.* ¶ 32, Dkt. 17-6. In both cases, the end result is fewer providers performing health and life-saving abortions. This, again, is an obstacle to EMTALA because it disrupts Congress's careful balance to avoid overly severe sanctions that could lead to providers deciding not to provide emergency care.

In sum, cutting back on emergency abortion care quantitatively and qualitatively is a plain obstacle to EMTALA, which Congress enacted to ensure that all individuals—including pregnant women—have access to a minimum level of emergency care.

## E. Likelihood of Irreparable Harm

Having concluded that that the United State is likely to succeed on the merits of its claims, the Court turns to whether the United States has shown it is likely to

suffer irreparable harm in the absence of an injunction.

The United States has met that burden, as Supremacy Clause violations trigger a presumption of irreparable harm when the United States is a plaintiff. *See generally United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011), *rev'd in part on other grounds*, 567 U.S. 387 (2012) ("[A]n alleged constitutional infringement will often alone constitute irreparable harm.") (citation omitted). As one court has explained, "The United States suffers injury when its valid laws in a domain of federal authority are undermined by impermissible state regulations." *United States v. Alabama*, 691 F.3d 1269, 1301 (11th Cir. 2012).

And so it is here. If Idaho's criminal abortion statute is allowed to go fully into effect, federal law will be significantly frustrated—as discussed in detail above. Most significantly, allowing the criminal abortion ban to take effect, without a cutout for EMTALA-required care, would inject tremendous uncertainty into precisely what care is required (and permitted) for pregnant patients who present in Medicare-funded emergency rooms with emergency medical conditions. *See generally United States v. South Carolina*, 840 F. Supp. 2d 898, 925 (D.S.C. 2011) (finding irreparable harm where state immigration law "could create a chaotic situation in immigration enforcement"). The net result—discussed further in the next section—is that these patients could suffer irreparable injury in the absence of an injunction.

### F. The Balance of Equities and the Public Interest

The next question is whether the balance of equities tips in the United States' favor and whether an injunction is in the public interest. As noted above, because the United States is a party, these two factors merge. The key consideration here is what impact an injunction would have on non-parties and the public at large. *Bernhardt v. L.A. Cnty.*, 339 F.3d 920, 931 (9th Cir. 2003).

Looking first to the public at large, in the most general sense, "preventing a violation of the Supremacy Clause serves the public interest." *United States v. California*, 921 F.3d 865, 893-94 (9th Cir. 2019) (citing *Arizona*, 641 F.3d at 366). As the Ninth Circuit has explained, "it is clear that it would not be equitable or in the public's interest to allow the state to violate the requirements of federal law, especially when there are no adequate remedies available. In such circumstances, the interest of preserving the Supremacy Clause is paramount." *Arizona*, 641 F.3d at 366 (cleaned up, citations omitted).

Next, based on the various declarations submitted by the parties, the Court finds that allowing the Idaho law to go into effect would threaten severe, irreparable harm to pregnant patients in Idaho. Speaking of patients, although the parties and the Court have often focused mainly on the actions and competing interests of doctors, prosecutors, legislators, and governors, we should not forget the one person with the greatest stake in the outcome of this case—the pregnant

patient, laying on a gurney in an emergency room facing the terrifying prospect of a pregnancy complication that may claim her life. One cannot imagine the anxiety and fear she will experience if her doctors feel hobbled by an Idaho law that does not allow them to provide the medical care necessary to preserve her health and life. From that vantage point, the public interest clearly favors the issuance of a preliminary injunction.

In that regard—and as discussed at some length above—the United States has submitted declarations from physicians explaining that there are any number of pregnancy-related complications that require emergency care mandated by EMTALA but that are forbidden by Idaho's criminal abortion law. Idaho physicians have treated such complications in the past, and it is inevitable that they will be called upon to do so in the future. Not only would Idaho Code § 18-622 prevent emergency care mandated by EMTALA, it would also discourage healthcare professionals from providing any abortions—even those that might ultimately be deemed to have been necessary to save the patient's life—given the affirmative-defense structure already discussed. Finally, if the abortion ban laid out in the Idaho statute goes into effect, the capacity of hospitals in neighboring states that do not prohibit physicians from providing EMTALA-mandated care (Washington and Oregon, for example)—would be pressured as patients may choose to cross state lines to get the emergency care they are entitled to receive

under federal law. See Dkt. 45-1, at 16-17.

Turning to the other side of the equitable balance sheet, the State of Idaho will not suffer any real harm if the Court issues the modest preliminary injunction the United States is requesting. In fact, as a practical matter, the State (and, to a much greater extent, the Legislature) argue that physicians who perform the types of emergency abortions at issue here won't violate Idaho law anyway; therefore, by their own reasoning, they will suffer no harm if enforcement of § 18-622 is enjoined on this limited basis. And although the State has argued that in the wake of *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), the public interest lies in allowing states to regulate abortions, *Dobbs* did not overrule the Supremacy Clause. Thus, even when it comes to regulating abortion, state law must yield to conflicting federal law. As such, the public interest lies in favor of enjoining the challenged Idaho law to the extent it conflicts with EMTALA.

#### **ORDER**

#### IT IS ORDERED that:

- 1. Plaintiff's motion for a preliminary injunction (Dkt. 17) is **GRANTED**.
- 2. The Court hereby restrains and enjoins the State of Idaho, including all of its officers, employees, and agents, from enforcing Idaho Code § 18-622(2)-(3) as applied to medical care required by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. Specifically, the State of

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

**3.** This preliminary injunction is effective immediately and shall remain in full force and effect through the date on which judgment is entered in this case.

**DATED:** August 24, 2022

B. Lynn Winmill

United States District Judge

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

# STATE OF IDAHO'S EXCERPTS OF RECORD Volume 2 of 3

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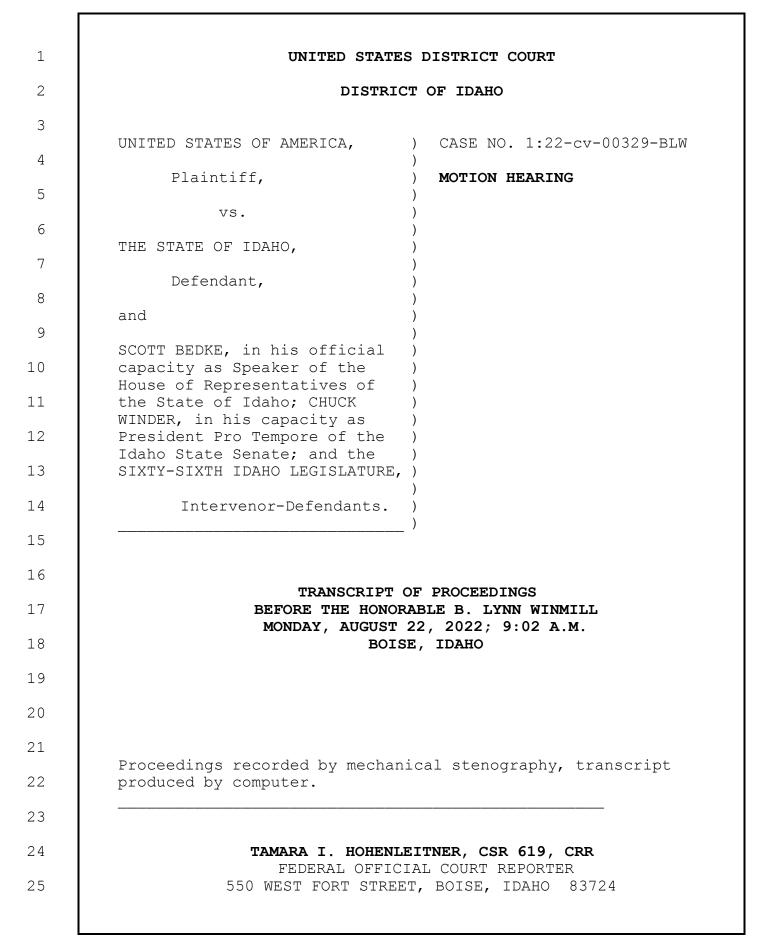
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#### PROCEEDINGS

August 22, 2022

THE CLERK: The Court will now hear Civil Case 22-329,

United States of America vs. The State of Idaho, regarding

plaintiff's motion for a preliminary injunction.

THE COURT: Good morning, Counsel.

Before we take up this matter, I did want -- we did provide a call-in number. I don't know if anyone has taken advantage of that, but it's something that we have only been able to do during the pandemic. But I did need to remind anyone who is listening in that it is against federal law to try to record court proceedings even from a remote location.

Of course, that would apply to anyone here in the courtroom as well, but we're usually not as concerned about that happening as we would if someone were simply listening in by a telephone connection.

As we begin, I have given counsel 45 minutes per side.

I'm going to make some initial observations intended just to

point out where I have some concerns so that you can target your

argument appropriately.

I do want to point out at the outset my appreciation for the considerable energy and skill demonstrated by the briefs and declarations which the parties have submitted. It's been immensely helpful, created a lot of work. The amicus briefing was also excellent and provided, I think, a real broad

understanding as to the various points in this.

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Now, before I actually get to offering those initial observations, I hope it is clear to everyone here, this is not a case about the wisdom of *Dobbs* or the wisdom of *Roe v. Wade*.

That really is completely secondary to this decision. *Dobbs* is the law of the land, and that will not be questioned here. The only question is resolving a conflict or apparent conflict between federal and state law under the supremacy clause of the United States Constitution.

Now, let me address some of the concerns. I think I have two or three concerns for the State and one concern for the Government, but I'm offering them here because you both may want to comment on them.

It struck me that the State, both in their brief -- both in their briefing and in their declarations, attempted to state their arguments in language other than what was actually included in Idaho's abortion statute.

Routinely you argued, both in briefing and in declarations, that the statute provides an affirmative defense to a doctor who may be prosecuted under its provisions if the doctor has a good faith belief that the abortion was necessary because the medical condition was life-threatening. That's the word that was kind of pretty consistently used throughout the briefing and declarations.

The United States, in its reply brief, makes a

compelling argument that this is a rewriting of the statute since the statute only permits the affirmative defense if the abortion was, quote, "necessary to prevent death," close quote.

So the question is: Does the statute provide for an affirmative defense if the medical condition would be, without an abortion, life-threatening, or is the abortion truly necessary to prevent death, or are they the same thing?

But relying on Black's Law Dictionary and Idaho
Supreme Court cases, the U.S. makes a strong argument that
"necessary" means indispensable or absolutely needed.

And I guess I have to share that I have the same concern that the statute would only provide the doctor with an affirmative defense if he or she believed in good faith that the patient would, in fact, die unless the abortion is performed. And that is quite different from simply being life-threatening, which suggests only a possibility of death.

So that's one issue I really want the State to hit head on. And I would note you didn't have a chance to respond to it because it came up in the reply brief. But then it only came up in the reply brief because it was a kind of reframing of the issue by the State in its response brief.

The second question is somewhat related, and it's simply this: That even if the "necessary to prevent death" language can be read as meaning life-threatening, that deals only with situations where the patient's death is either going

to happen or is at least a probability.

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But there are situations which I think have been pointed out primarily in the amicus and the United States' submissions where a doctor may well believe that in the hospital setting, they can prevent or substantially reduce the chance of the patient's death, but that there is still a substantial likelihood that the patient will be left with serious medical injuries if an abortion is not performed. They may be left infertile or have temporary or permanent major organ failure or have a stroke, leaving the patient with long-term serious disability.

As I would note, the submissions from the United States suggest that is more than just a hypothetical concern.

My concern is that in that setting, where the death of the patient is not likely but it is still going to have very serious medical consequences for the patient, there would seem to be just an absolute conflict between EMTALA and the Idaho abortion statute.

So on that front, it strikes me at least initially that the impossibility preemption applies. And I need to have the State hit that head on, why that is not truly a conflict between the statutes.

Okay. For the Government, here is the concern I would like to make sure you address: In this case, it appears that we

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have express preemption because of the language of EMTALA. And since the touchstone of preemption is Congressional intent, then is it not true that the Idaho abortion statute is only preempted if it directly conflicts with EMTALA? That's the language in EMTALA itself. There must be a direct conflict, or there is no preemption.

So does that make the implied preemption principle, such as impossibility and obstacle preemption, not relevant?

And then how does that bear upon this case?

So those are the three concerns I thought I would throw -- I know I'll have questions as we get into this more deeply, but I wanted counsel to be aware of at least those three concerns.

I guess just one last observation that is more general in nature. You know, I have been a judge for a lot of years. I have sat and observed the application of our criminal laws, and I think it's pretty obvious that our legislature and Congress think that passing criminal laws will change behavior. And from my time on the bench, I have seen that change in behavior applies not just in the core of the criminal statute but around the edges.

Simply put, we assume that rational people will not just literally comply with the criminal statute but will avoid conduct which might even be viewed as violating the statute simply because of the impact of being charged even if you're

able to obtain an acquittal.

Intentionally or otherwise, the abortion statute, if that premise is correct, will cause doctors to steer clear of conduct that could be seen as violating the Idaho abortion statute. It would be a rare situation where a doctor is going to be willing or anxious to push the limits and go right up to the edge of what is allowed under the Idaho abortion statute. In essence, they will seek a safe harbor in which they have no chance of prosecution.

Does that almost not create obstacle preemption if the doctors are risk averse? I mean, I think it's in the very nature of their profession.

So I want, again, counsel to be aware that I just had that general concern that really is a reflection of what I have observed as a judge in handling a lot of criminal cases and kind of having a sense of what Congress and the legislature intend when they pass criminal laws trying to not only criminalize behavior but change behavior both directly within the statute and on its edges.

So, with that, let's go ahead and begin.

Mr. Netter, I think you'll start. I understand you're going to reserve 20 minutes for rebuttal. And we have a clock, which is more for your aid. I actually use it pretty strictly in some cases to keep attorneys on time. I don't think that will be too much of an issue because we have given you a lot of

time to argue, but it will give you some idea of where you are with the time allotted.

So, Mr. Netter.

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MR. NETTER: Thank you, Your Honor.

Good morning, Your Honor. May it please the Court.

Brian Netter, U.S. Department of Justice, for the United States.

Each of us will, at some point in our lives, encounter a medical emergency for ourselves, for a friend, for a loved one. We hope that when that point of medical crisis arrives, the person in need is able to get to a hospital where a doctor or a nurse who has trained their entire professional life for that moment, trained for years, will know the right treatment to administer.

And although perhaps it should go unsaid, we hope that in that moment, the doctor or the nurse will be able to administer the treatment, will not be precluded, will not be forced to hesitate out of fear that the doctor or nurse, him or herself, will face criminal sanctions.

As the Court has acknowledged, this case arises under a federal law called EMTALA, the Emergency Medical Treatment and Labor Act. Under EMTALA, when a patient arrives at a participating hospital with an emergency medical condition, the physician is required to offer what's called a stabilizing treatment. Any state law that conflicts directly with that requirement is preempted.

So let me address right here at the outset the Court's question about what preemption means in the context of EMTALA, because that is governed by binding Ninth Circuit precedent, a case called *Draper vs. Chiapuzio* that was decided by the Ninth Circuit in 1993.

In that case, the Ninth Circuit said, while construing EMTALA, the key phrase is "directly conflicts." A state statute directly conflicts with federal law in either of two cases:

First, if compliance with both federal and state regulations is a physical impossibility or, second, if the state law is, quote, "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."

So we believe that answers the question and that both physical impossibility and obstacle preemption are within the scope of the statutory preemption provision of EMTALA.

THE COURT: Yeah. I read that decision, and I can't disagree with it because it is -- well, I guess I can disagree with it. I have to follow it because it's the Ninth Circuit precedent. But it struck me as a little odd because there does seem to be express preemption; and, as such, we look directly at the language of the statute. And the statute says there is only a conflict or preemption if there is direct conflict.

But you're right. I mean, that is the case that I think governs that, but, you know, I'm going to -- I will wait to hear what the legislature and the State of Idaho has to say,

but I did wonder at the time when I read the decision that they seemed to be going a little further than they needed to; and where there is express language about preemption, that would seem to govern the issue.

But you hit the exact case. I mean, that was exactly the response I thought you would make, but I wanted to hear you make that argument.

Go ahead.

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MR. NETTER: Well, let me just add one additional point on that, Your Honor, which is that the legislative history of EMTALA indicates that the purpose behind the preemption provision was to ensure that states would be able to enforce stricter laws that required even greater provision of emergency care.

So it's sensible in that circumstance for the preemption provision to be interpreted to prevent a state from erecting obstacles to the full purposes and objectives of Congress.

So we're here today, of course, because sometimes a patient who arrives at a participating hospital with an emergency medical condition is pregnant. And sometimes the stabilizing treatment that is necessary to save the life or protect the health of that patient is an abortion.

And yet, Idaho has a law set to go into effect this week which the state supreme court has described as a total

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abortion ban that is poised to subject doctors and nurses who participate in any abortion to the felony criminal process.

Now, as the briefing in this case has demonstrated, there are some issues on which the State, the legislature, and the United States agree. Principally, everybody seems to agree that there is some preemption; and to the extent that EMTALA governs, the State of Idaho doesn't have the authority to override that.

Additionally, the State and the intervenors appear to agree that EMTALA does require abortions as a stabilizing treatment under some circumstances.

The primary dispute between the parties is whether there is an actual dispute: what the scope of the Idaho law is, and how that compares to the protections afforded by EMTALA.

With respect to that, there are both legal and factual angles. Primarily, of course, the interpretation of EMTALA and the interpretation of Idaho law, that's a question of law for this Court to determine.

Now, there are some additional factual questions as to what actual medical conditions can arise that fit within the gap between Idaho law and EMTALA.

As has been identified in the briefs and in the accompanying declarations, there are a number of conditions that affect pregnant individuals that would fall within this gap, potentially including ectopic pregnancy, preterm/prelabor

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rupture of membranes, placental abruption, preeclampsia with severe features, sepsis, cardiovascular disease, and the list goes on.

I would like to discuss a bit the facts and the powerful declarations that were submitted by obstetricians and gynecologists within the state of Ohio [sic] who are set to be subject to this law in the coming days.

But first we should start with the law. Because the way that 18-622 was crafted here is very telling, because the Idaho Code part governing abortion contains a definition. It has a definition for medical emergency. And the legislature told us in its motion to intervene, Docket 15-1, that the definition of medical emergency in the Idaho Code, which was used by the legislature in the 2021 Heartbeat Law, was designed to track EMTALA, and that 18-622, the Total Abortion Ban, was intended to be narrower. When the legislature told us that, we should believe it.

It's a standard canon of statutory interpretation that when Congress or when a state legislature uses different language to cover different concepts, a different outcome is intended. That was certainly the case here.

There was an article published in the *Idaho Capitol*Sun on Friday that transcribed some of the colloquy in the committee hearing of the legislation that resulted in 18-622.

And I found that to be rather telling.

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During the hearing of the House State Affairs

Committee, Representative Brooke Green asked the sponsor of the legislation, Representative Todd Lakey, why there was no exception for the health of the pregnant individual.

What he said is: "If you're talking about the health of the mother, that's a nuanced decision that could be something much less than life, where if the decision was based solely on a question of some type of health, then you're talking about taking the life of the unborn child," he said.

After Representative Green asked if that meant that the health of the woman was irrelevant, Representative Lakey said, "I would say it weighs less, yes, than the life of the child."

So I think this indicates, Your Honor, that the different framing, the different phrasing "necessary to prevent the life" [sic] as opposed to the much broader categories that appear in EMTALA and that appeared even in other abortion restrictions adopted by this legislature, that that's significant.

There is a reason why different language was adopted here, and that reason requires the injunctive relief that has been requested by the United States.

Of course, the text of 18-622 confirms that to be true. The language "necessary to prevent the death" is not couched in probabilistic terms. Necessary is absolute; it means

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indispensable. The State confirmed as much in its submission to the Idaho Supreme Court just 32 days ago in *Planned Parenthood*Great Northwest vs. State.

In response to an argument that this language was vague, the State said that the affirmative defense is available only if the procedure is, quote, "essential to stop the death of a pregnant woman."

THE COURT: This was from the oral argument before the Idaho Supreme Court?

MR. NETTER: That was in the briefing --

THE COURT: The briefing.

MR. NETTER: -- that led to the oral argument. Yes, Your Honor.

It's no wonder, under that standard, that physicians are fearful of practicing under a regime in which federal law and the Hippocratic oath require the provision of care, but Idaho law says that providing the care potentially makes you a felon.

So now much of the briefing, as a factual matter, has hinged on the question of what the legislature calls relevant abortions and whether they exist. The reality, which I think each of us has experienced over the course of our lives, is that pregnancies sometimes have complications. And that's true in Idaho just as it's true everywhere else.

The legislature submitted what it called some official

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data, trying to suggest that emergency abortions are exceedingly rare in Idaho and that there have been only a handful over the period covered by the data, the past 10 to 12 years. So I wanted quickly to point out why that assessment of the data is manifestly incorrect.

The legislature looked at official data that covered only pregnant individuals who were less than 18 who were also unable to obtain the consent of their parents or guardians or pregnant individuals who were seeking an abortion more than 20 weeks after fertilization, which is at a gestational age of 22 weeks or later.

There is additional data that we have submitted in our papers -- this is at Docket 86-6 at 10, which is ECF page 11 -- that indicates that abortions that take place after 22 weeks' gestational age account for something like 0.1 percent of the abortions in Idaho.

So the suggestion that there aren't emergency abortions in this state is unfortunately incorrect, and the declarations that we have submitted demonstrate that to be the case.

And these are not only procedures that take place at the moment where the doctor knows that if the procedure does not happen, the patient will die. Medical needs occur on a spectrum where there are times when a disease will progress, where there could be organ damage, where there could be serious implications

for a patient's health and where waiting for additional treatment is going to cause even greater complications. And then there may be a later time when it is actually the case that an abortion is truly necessary to save an individual's life, but the costs that are borne during that interim period are serious and reflect some of the delta between EMTALA and Idaho law.

I would refer the Court in particular to the supplemental declaration of Dr. Emily Corrigan, who is an obstetrician/gynecologist at Saint Alphonsus here in Boise. And that's at Docket 86-3, and her initial declaration was at Docket 17-6.

She identified three patients on which she was aware of actual emergency abortions that had been necessary, Jane Does 1, 2, and 3.

Jane Doe 1 experienced preterm/prelabor rupture of membranes, and Dr. Corrigan said in her supplemental declaration that, in some circumstances, it could become serious enough to result in death, but it might just require limb amputations or a hysterectomy.

Jane Doe No. 2 was suffering from a placental abruption, where the placenta prematurely detaches from the uterine wall. That condition, she testified, might just cause kidney failure or a brain injury.

Jane Doe 3 had a condition called water on the lungs that might just cause a lung injury rather than death.

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Considering all this, Dr. Corrigan explained that she told her hospital that OB/GYN physicians in Idaho are, quote, "bracing for the impact of this law as if it is a large meteor headed toward Idaho."

Now, it nearly goes without saying in the text of EMTALA, the circumstances in which stabilizing treatment must be offered are considerably broader. EMTALA is phrased in probabilistic terms: When the absence of treatment is reasonably expected to result in placing the health of a patient in serious jeopardy, in serious impairment to bodily functions, in serious dysfunction of any bodily organ or part.

The conditions described by Dr. Corrigan plainly describe there being abortions that are necessary under EMTALA, that are required as a matter of federal law that Idaho law would set -- is poised to criminalize.

There is also, of course, a fairly common complication of pregnancy, ectopic pregnancy, that is discussed in the briefing.

Dr. Amelia Huntsberger in Sandpoint, Idaho, at Docket 86-4, explains that not every patient with an ectopic pregnancy will die without treatment, which I take to mean that there are circumstances in which it may be possible, theoretically, to wait for a fallopian tube to rupture and for the fetal heartbeat to stop before trying to clean up the internal bleeding and organ damage.

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Now, the legislature has argued that ectopic pregnancy -- that treatment of an ectopic pregnancy is not within the scope of the law. The State, notably, has not taken that position.

And the legislature has not grappled with the statutory text in the slightest in trying to explain to this Court or to physicians why the treatment of an ectopic pregnancy would not constitute criminal abortion under Idaho law.

As the Court indicated, with respect to obstacle preemption, there are questions here about the chilling effect. And one thing I haven't discussed yet is the very peculiar manner in which the supposed exception of this law is structured: That ordinarily if a state were to want to criminalize abortion except in certain circumstances, it would be the burden of the prosecutor to establish that those circumstances were not met, and the prosecutor would have to make that proof beyond a reasonable doubt.

Here, however, the presumption is flipped. Here, a prima facie criminal violation is established any time an abortion is performed within the state of Idaho. Full stop. The only way for a physician to avoid becoming a felon and going to jail for up to five years is by proving up the affirmative defense and convincing the jury, on the physician's burden or on the nurse's burden, by a preponderance of evidence that this narrow affirmative defense has been satisfied.

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It hardly seems necessary to point out that doctors would avoid the risks of a criminal trial if at all possible. But, again, we have declarations to demonstrate that that's the case.

Dr. Kylie Cooper, an OB/GYN and maternal-fetal medicine specialist at St. Luke's here in Boise, said in her supplemental declaration, Docket 86-5, that as a physician who is practicing in Idaho and through her personal interactions with healthcare providers around the state, as well as through her positions with ACOG, the American College of Obstetricians and Gynecologists, the Idaho Perinatal Project Advisory Board, and the Idaho Coalition for Safe Reproductive Healthcare, providers' fear -- provider fear and unease is real and widespread.

The State and the legislature don't have any response to this. Indeed, the Attorney General's Office doesn't seem to argue on this point at all. They don't dispute the chilling effect.

The legislature insists that prosecutors would exercise their discretion prudently. As a matter of law, that simply doesn't matter. The Ninth Circuit held in *United States vs. City of Arcata* that in that case, the City's promise of self-restraint does not affect our consideration of the ordinance's validity.

That's the case here. And I think that it is

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transparently the case that submitting a declaration from one county prosecutor in a state that has 43 elected county prosecutors provides no comfort to the physicians and the nurses -- excuse me -- of this state.

Because, as Dr. Huntsberger pointed out in her declaration, the very nature of discretion is that different people are going to exercise it differently.

And even if it were the case that all 43 county prosecutors could attest to the fact that they didn't intend to prosecute under these circumstances, Idaho law has a provision under which a member of a grand jury can identify the commission of an offense and that fellow jurors must thereafter investigate the same. That's Idaho Code 19-1108.

Likewise, there is a citizen complaint provision whereunder any individual within the state of Idaho can go to a magistrate with a criminal complaint. Under those circumstances, the magistrate doesn't appear to have discretion. If the elements of the crime are satisfied, then the magistrate has to endorse the complaint.

And even if these procedures were not sufficiently troubling, there is the fact of the statute of limitations.

There is a five-year statute of limitations on felonies in Idaho, which means even if today's prosecutors decided that they were not inclined to prosecute these offenses, nothing would prevent a future prosecutor, perhaps one elected after today's

date, from taking up abortions that happened during the interim. 1 2 So, Your Honor, the United States filed this action 3 because federal law contains a requirement. The requirement is for emergency care to be offered under certain circumstances, 4 5 that federal law preempts contrary state laws. And the 6 preemption effect is particularly powerful here, where lives, 7 livelihood, and health are surely on the line. The State's legal interpretation of its statute 8 9 doesn't measure up and isn't consistent with the interpretations 10 that the State offered to its own supreme court only a month 11 ago. And the factual circumstances demonstrate that the need 12 for judicial intervention is dire. So I'll be happy to respond to any additional 13 14 questions the Court has or to respond after the State and legislature have an opportunity to speak. 15 16 THE COURT: I may have more questions after. 17 you're going to reserve the balance of your time? 18 MR. NETTER: I will, Your Honor. Thank you. 19 THE COURT: Very good. Thank you, Mr. Netter. 20 Mr. Church. 2.1 MR. CHURCH: Thank you very much, Your Honor. 22 THE COURT: While you're getting up there, I would 23 like you to respond to Mr. Netter's -- well, to the issue of 24 whether or not an ectopic pregnancy is a pregnancy. 25 Just looking at the plain language of the statute, I

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know there has been an argument that it's not -- or at least it's not an abortion to end an ectopic pregnancy, but the "abortion" is defined as "terminating any clinically diagnosable pregnancy," and "pregnancy" is defined as "having a developing fetus in the body and commences with fertilization."

Isn't even an ectopic pregnancy a developing fetus after fertilization? And why is that not kind of dispositive on that issue?

I'm only asking that question now because that was kind of the last point that Mr. Netter made, and it was on my mind. Go ahead.

MR. CHURCH: Good morning again, Your Honor. May it please the Court. Deputy Attorney General Brian Church on behalf of the State of Idaho.

Let me begin by tackling the question you just asked,
Your Honor. And as the State, I am bound by what the
legislature has wrote with respect to what a definition is of an
abortion under Idaho Code 18-604(1).

Your Honor, it is our understanding that with respect to an ectopic pregnancy, that that would be defined as a pregnancy under law and that it would be direct with respect to your question.

Now, in this case, Your Honor --

THE COURT: Just so we're clear, then, that necessarily follows that if you end that pregnancy through an

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abortion, through a termination of the developing fetus in the
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         fallopian tube, that that would be an abortion?
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                   MR. CHURCH: Yes, Your Honor, again, based upon Idaho
         Code 18-604(1).
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                   THE COURT: And sub 11, which I think is the
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         definition of pregnancy.
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                   MR. CHURCH: That would be correct, Your Honor. And
         with respect to sub 1, which defines abortion, the State is
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 9
         bound by the definition --
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                   THE COURT: Okay.
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                   MR. CHURCH: -- that has been provided, Your Honor.
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                   THE COURT: Thank you for your candor. Go ahead.
                   MR. CHURCH: I appreciate that. Thank you very much,
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         Your Honor.
                   In this case, Your Honor, the United States asked this
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         Court to enjoin Idaho from enforcing Idaho Code Section 18-622
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         against any provider in every instance where 18-622 and the
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         Treatment Act may apply. This Court should deny the preliminary
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         injunction for four reasons.
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                   First, the United States has not shown that every
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         abortion performed as a stabilizing treatment would conflict
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         with 18-622 and so has not met its burden for a facial
23
         challenge.
24
                   Second --
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                   THE COURT: All right. Well, let me -- you're going
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to challenge my memory here. Go ahead and make the four points, but I'm going to have questions about all of them, because the whole issue of as applied or facial challenge, I don't understand the United States to be arguing that the entire statute is invalid, only that it's invalid when applied in an emergency room setting where there are EMTALA obligations.

How does that become -- well, I will ask you, when you finish your list -- so be prepared -- why that makes it a facial application. And then the follow-up question is: Why does it matter?

Go ahead. And you have to understand, I'm going to have a lot of questions here. And I will try to ask them in a way that does not disrupt the flow of your argument, but I can't promise that. So go ahead.

MR. CHURCH: Your Honor, I appreciate the interruption. And I appreciate the opportunity, on behalf of the State, to answer the Court's questions.

As Your Honor has indicated, I would like to finish the four points, and I will directly respond to your question about the facial challenge.

The second reason, Your Honor, that this Court should deny the injunctive relief is that the Treatment Act with its savings provision, which is 1395dd(f), does not preempt Idaho from imposing criminal consequences for a violation of 18-622, as the savings provision allows each state law requirement to

stand unless it directly conflicts with the requirement in the Treatment Act.

THE COURT: Yeah. That was my discussion with Mr. Netter. And that's, I think, an issue he has to address. So you will need to be prepared to address the Ninth Circuit's take on that language, which I'm not sure I understand but I have to follow.

So go ahead.

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MR. CHURCH: I appreciate that, Your Honor.

The third reason why the Court should deny injunctive relief in this case is that there is no direct conflict with a Treatment Act requirement because Idaho chose to make an exception to criminal liability and affirmative defense which has the doctor assert a subjective good-faith medical judgment as his or her defense.

THE COURT: And I will ask you, once you have completed -- that it's not an exception; it is an affirmative defense.

Do you agree with that?

MR. CHURCH: Well, Your Honor, it is an affirmative defense, but it's also an exception to criminal liability. And it's just the way in which the burden shifts, Your Honor.

As even Mr. Netter pointed out, under a typical exception, which, like the fetal heartbeat, for instance, would have, it would be the burden of a prosecutor.

THE COURT: To prove beyond a reasonable doubt that the exception does not apply?

MR. CHURCH: That would be correct, Your Honor.

But, as we'll point out in just a moment, I'm not sure that there is any material difference between an affirmative defense which has the physician maintaining the burden and the prosecutor maintaining a burden; each that proves an exception to criminal liability, at least for preemption purposes, Your Honor, and at least with respect to a direct conflict with a Treatment Act requirement, which is what the savings provision requires.

THE COURT: Okay.

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MR. CHURCH: The fourth reason, Your Honor, why the State of Idaho would ask this Court deny injunctive relief is that even though the United States' declarants made clear that they could determine when an abortion was necessary to preserve the life of a pregnant woman, the United States has not shown that doctors in all instances would be chilled by an alleged conflict between 18-622 and the Treatment Act such that the entire purpose of the Treatment Act would be nullified.

Your Honor, I understand you wanted me to first address the question about the facial challenge, and I would like to go ahead and go there now.

THE COURT: Yes.

MR. CHURCH: So, Your Honor, my understanding of the

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United States' requested relief in this case is for a preliminary injunction. I'm going to go to their filing of their proposed order, which is at Docket 17-2.

The proposed order in this case, as I understand, seeks an injunction of the State not only as with respect to the United States itself but that would enjoin the State from applying Idaho Code 18-622 to any abortion performed by any physician or hospital within the state of Idaho.

And that would be the second full paragraph of the -- or the second further-ordered paragraph that is in that -- in that docket.

And the reason why I point that out, Your Honor, is because, as I understand the relief that's requested in this case, it is relief that is beyond just the United States itself; it's relief that goes to additional parties.

THE COURT: Well, Counsel, I wanted to -- well, I checked the transcript to see if I heard you correctly. You are saying that the State is requesting that 18-622 have no application in any emergency room in the state of Idaho? Are you saying that's the requested relief?

MR. CHURCH: No, Your Honor.

THE COURT: Okay. I misunderstood. Would you restate that so I'm sure, so that we are clearly communicating here.

MR. CHURCH: Sure. I want to be clear on that, Your Honor. Thank you.

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THE COURT: Well, let me take a stab at the way I understand the relief requested, which is that 18-622 would have no application in any emergency room which has been provided with Medicare funding and where EMTALA would require that an abortion be performed. That's my understanding of what the United States is asking.

MR. CHURCH: Let me add one caveat to that, Your Honor.

I think, in addition to that, one of the things that's being requested or as part of that request, Your Honor, is that the State of Idaho not be allowed to either take criminal action against or licensing action against any physician or hospital as a result of an alleged conflict between 18-622 and the Treatment Act.

So, Your Honor, the scope of relief is going beyond just the United States here. It would also apply in circumstances to persons who are not even parties to this proceeding, namely, physicians and potentially hospitals as well.

THE COURT: Are you arguing this as a standing issue?

MR. CHURCH: No, I'm not arguing this as a standing
issue, Your Honor. I'm arguing this as part of why this is a
facial challenge.

Because some of the case law -- the *John Doe* case that we cited, for instance -- I think helps make this point that

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some of the relief here is going beyond just a particular abortion that maybe the United States would be raising to the State of Idaho.

Recall, Your Honor, that this pre-enforcement challenge is going at every single time an abortion may be provided as stabilizing treatment under the Treatment Act, and the United States is attempting to block the enforcement of 18-622 in every single instance.

And for that reason, Your Honor, we believe that this is a facial attack that the United States bears the burden under the *Salerno* test of showing that there are zero instances where 18-622 can be applied with the Treatment Act.

And, Your Honor, we believe clearly -- and as the original declarations seem to indicate -- the doctors in this case are able to determine what is necessary to preserve the life of a woman or necessary to prevent the death of a pregnant woman, which is what 18-622 authorizes.

So we are not seeing a direct conflict in those instances, Your Honor. As such, that would defeat the facial challenge in this case, because there are certainly instances where Idaho Code 18-622 can be applied where there is an abortion provided as stabilizing treatment under the Treatment Act.

As such, because it's a facial challenge, that is the key point, Your Honor, is that they haven't met their burden of

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showing that there is zero instances where those two acts can be applied together.

Now, Your Honor did ask about our position on life-threatening versus necessary to prevent the death or necessary to preserve the life of a woman. And I do want to address that, Your Honor.

And I guess one point is -- that I would note is that our understanding of what the language means with respect to Idaho Code 18-622 is that it's consistent with, I think, the general purpose of the Hyde Amendment, the current Hyde Amendment that governs the federal trust funds that are provided for Medicare purposes.

And this is from Public Law 117-103. It's one of the laws cited by the United States. And I am specifically reading from 136 Statutes at Large 496. And this is Section 507.

It explains that the limitations established in the preceding section, which as I understand it generally prohibit the funds -- federal funds from going to abortion, do not apply to an abortion, one, if the pregnancy is the result of an act of rape or incest -- which is covered as part of 18-622, Your Honor -- or, second, in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion

is performed.

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THE COURT: I'm not sure I completely understand why that statute is relevant when we have -- that's a federal statute. And is it directly applicable to the EMTALA obligations?

MR. CHURCH: Well, it's not directly applicable, Your Honor, but it's also -- it's consistent with -- we are offering it solely to show that our interpretation is consistent with the --

THE COURT: Well, you're saying that the Idaho legislature, when they said that the abortion was necessary to avoid the death of the patient, that they were really thinking what Congress said when they are dealing with it in a totally different context. I'm not sure I understand how that flows.

MR. CHURCH: Well, let me make two points with respect to that, Your Honor. I think the first point, you said "necessary to avoid the death of the woman." That's not the language of the statute.

THE COURT: Well, I was paraphrasing. But the word "necessary" is there, and that's the operative term.

MR. CHURCH: That is correct; the word "necessary" is there. And it's necessary to prevent the death of the pregnant woman.

I offered the example of the current Hyde Amendment simply to show that our interpretation of Idaho Code 18-622

appears to be consistent with what the Hyde Amendment provides as a matter of federal law.

It's not to shed light on exactly what 18-622's terms mean. That would be a question of law, as Mr. Netter pointed out, for this Court or, really, the Idaho Supreme Court to determine.

And, Your Honor, with respect to that, you know, that's also why we could have an as-applied challenge as part of a prosecution. If there truly is a prosecution, Your Honor, of a physician, that physician could argue that the abortion was, in his or her good-faith medical judgment -- which is a subjective standard -- that the abortion was necessary to prevent the death of a woman.

That is a subjective standard, and the Court would be well -- in a criminal prosecution would be well capable of handling determining whether the -- whether the physician has made that showing and made -- made clear that the affirmative defense would apply.

THE COURT: Let me ask -- and this came up from Mr. Netter's suggestion that, within the last few weeks, your office has appeared before the Idaho Supreme Court and argued, to avoid a suggestion of ambiguity, that the statute clearly requires that the procedure of abortion was essential to prevent the death of a pregnant woman.

Essential is different than a risk.

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Again, I don't know if you argued that or not or if someone else in your office did, but I'm sure your office wants to be consistent.

Could you kind of just explain why that should not be troublesome to the Court.

MR. CHURCH: Sure. That should not be troublesome to the Court for a couple reasons.

And first, let me point -- I agree with Your Honor that there is nowhere in the statute Idaho Code 18-622 that the term "risk" is used with respect to -- that the abortion is necessary to prevent a risk of death of the pregnant woman. Instead, it's abortion is necessary to prevent the pregnant death of a woman.

Your Honor, I believe in that case, Mr. Netter is citing to language that is also citing from Black's Law Dictionary. I don't see any meaningful difference in the position that the State is taking here today with respect to its understanding of 18-622 and the position that it has taken before the Idaho Supreme Court.

You're right, Your Honor, it's a different attorney with that case. But I understand --

THE COURT: You're not throwing someone under the bus, are you?

MR. CHURCH: I am not throwing someone under the bus, Your Honor, because our position, I believe, is consistent

between the two cases. And even then, Your Honor, you know, this is a question of law for this Court if it decides it must interpret Idaho Code 18-622.

Again, the important facet from the State's perspective in this case, Your Honor, is that the United States has not shown in all instances that there is a direct conflict between Idaho Code 18-622 and the Treatment Act. Because there are certainly cases where the abortion was necessary to prevent the death of the pregnant woman, as some of the declarations from the United States' declarants in their original submission made clear.

Now, one -- the second point I had, Your Honor, that I did want to move on to and address was in the United States' response brief, they appeared to make an argument that the State of Idaho was categorically preempted from exercising either civil regulatory or civil sanctioning or criminal sanctioning authority with respect to any stabilizing or any type of treatment that would be offered as a stabilizing treatment. And that's page 19 of their reply brief that I'm looking at.

I would note that if their argument is that there's a categorical rule prohibiting some criminal prohibition of manners of treatment, such as abortion, first, that that would be inconsistent with the savings provision in 1395dd(f). Recall that 1395dd(f) allows every state law requirement to stand unless that state law requirement directly conflicts with a

requirement in EMTALA or the Treatment Act.

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Now, with respect to that, Your Honor, my note would be that the case law has established that state malpractice actions, for instance, have been authorized against physicians or providers. Moreover, even the act itself provides for civil regulatory penalty --

THE COURT: Why would a malpractice action create a conflict with EMTALA?

MR. CHURCH: And that's my point. It does not create a conflict.

THE COURT: Here, their argument is that there is a conflict. So why is that apropos to what we're discussing here?

MR. CHURCH: Well, it's apropos because we are contending that there is no conflict in allowing the State to even have a criminal prohibition in the first place.

My understanding is that the United States has raised a categorical argument.

THE COURT: Well, there is no conflict if the criminal prohibition provides an exception that would fall and satisfy the three categories of EMTALA where medical care is necessary even if it includes an abortion.

That's the whole point of this, is whether there is no exception for injury short of death. And it's stated as an affirmative defense in which the burden is on the doctor to prove by a preponderance of the evidence the existence of the

condition -- the circumstance rather than the burden being upon the State to prove beyond a reasonable doubt that it does not exist.

And I can tell you, having presided over hundreds of criminal trials, that is a huge difference. So...

MR. CHURCH: Well, and I appreciate what Your Honor has recognized. And I am just responding to one argument that was made in the United States brief.

But you're right. The United States also contends, as we understand it, that 18-622 -- and this is at pages 7 to 8 of their brief -- that 18-622 is problematic because it places an affirmative defense on the physician and places the burden on the physician to prove that affirmative defense.

Now, I did want to make one note is that, as part of their briefing, the United States cites to the Fetal Heartbeat Act as an example of a law that allows exceptions. And my understanding of the United States' brief is that, under their envisioning, the Fetal Heartbeat Act itself is not in direct conflict with EMTALA or the Treatment Act simply because it has an exception within it.

Now, one additional aside I should note for Your Honor is that the Fetal Heartbeat Act, as of Friday, August 19, did go live and is effective. And it does currently govern physicians within the state. And so physicians within the state are bound by 18-8804 and 18-8805 -- excuse me, Your Honor -- with respect

to the criminal prohibitions that are within 18-8805. 1 As the Court well knows, though, under 18-622 --2 3 THE COURT: Are you suggesting that the fetal heartbeat law has superseded the criminal abortion statute? 4 MR. CHURCH: No, Your Honor, but let me clarify that. 5 6 So under 18-8805 and I believe it's sub 4, 18-8805 was 7 presumed to go in effect first and has now gone into effect first. When 18-622 became enforceable, at least the criminal 8 9 provisions of 18-622 became enforceable, that statute, 18-8805, 10 provided that the criminal prohibitions if 18-622 were 11 enforceable would supersede 18-8805's, or the Fetal Heartbeat 12 Act's, criminal prohibitions. 13 Again, right now, as we stand today, Your Honor, the 14 Fetal Heartbeat Act is effective and it is active within the 15 state of Idaho. 16 THE COURT: But not in criminal prosecutions? 17 MR. CHURCH: It is effective with respect to criminal 18 prosecutions, Your Honor. 19 THE COURT: I thought you just said that the 18-622 20 said that any contrary provision has to give way to its 2.1 provisions. Did I --22 MR. CHURCH: When 18-622 is enforceable, Your Honor. 23 18-622 is not effective yet and is not enforceable yet. THE COURT: Well, as of Thursday, then it will. 24 25 that what you're saying?

MR. CHURCH: As of Thursday, assuming the Court does not enjoin it, it certainly will be enforceable, Your Honor.

THE COURT: Well, I certainly won't enjoin anything more than what the United States has asked, which is enjoin enforcement in the context where EMTALA would require medical treatment.

MR. CHURCH: Correct, Your Honor. And again, if 18-622 is not enforceable in those circumstances, then, by the terms of 18-8805(4), my understanding is that those criminal provisions would be enforceable, the Fetal Heartbeat Act provisions would be enforceable if 18-622 is not enforceable.

But the one thing I think Your Honor -- and Your Honor has hit upon it as well -- is that the difference in this case that's alleged is that there is a difference between Idaho's chosen mechanism of allowing an affirmative defense and allowing a doctor to show good-faith proof that it was a good-faith medical judgment based on the facts known to the physician at or -- at the time that the doctor makes the decision, that the abortion was necessary to prevent the death of a pregnant woman.

Now, under -- in a typical exception case where the prosecutor would bear the burden -- and my understanding with respect to 18-8805 and 18-8804 is that it is based upon an objective standard of whether the -- there was an emergency medical condition, for instance, under those statutes and that it uses an objective standard.

Now, what I don't understand, Your Honor -- and I think this is the point of disagreement between the State and the federal government -- is this: The United States appears to take no issue or have no issue with 18-8804 and 18-8805, the Fetal Heartbeat Act -- which provide for an exception process but still provide for criminal prosecution -- but takes issue and shows -- and says that there is a direct conflict when Idaho has chosen in 18-622 to impose an affirmative defense structure.

There is no good basis, in our -- in the State's view, to view the difference in the burden of proof or the subjective versus objective standard as being in direct conflict with the Treatment Act.

Now, the one case that the United States cites in its reply brief is Arrington. And I've had a chance to look at Arrington. I understand Arrington to be the Ninth Circuit reviewing an agency's -- I believe Health and Human Services' review of a hospital's ambulance diversion policy. It doesn't say anything about criminal liability or that the State is going to be preempted from having a criminal liability that is escapable through an affirmative defense.

There is simply no requirement, Your Honor, in the Treatment Act that, in our view, would be a direct conflict here with respect to a requirement of the Treatment Act and a requirement in 18-622.

Now, Your Honor had asked about the direct conflict

and what that means with respect to the Treatment Act. And, Your Honor, we're bound for these proceedings by the Ninth Circuit's decision in *Draper*, which, as Mr. Netter indicated, determined that the direct conflict means that there would either be -- that it would be physically impossible to comply with both Idaho Code 18-622 in this case and with the Treatment Act, or it would apply in those situations when the entire Act's purpose would be, as we pointed out in our briefing, effectively nullified, is the language from the Ninth Circuit that's used.

And in this case, Your Honor, we certainly don't believe that the standard that the State of Idaho has placed upon physicians to prove an affirmative defense is one that stands as a -- as essentially a nullification of the entire purposes of the anti-dumping Treatment Act.

Now, the last thing I wanted to just touch upon,
Your Honor, was with respect to the chilling argument. And
contrary to Mr. Netter's representation, we certainly did
challenge the assertion that there would be chilling in this
case. Let me make a couple points with respect to the chilling.

First, we understood the declarants in their original declarations to make perfectly clear that they could determine when an abortion was necessary to save the life of a mother.

THE COURT: Well, the declarations that you submitted didn't use that terminology. Typically, they indicated that

these were life-threatening and did not, I don't think, 1 2 directly -- or did they? If they did and you can point that 3 out, I'll stand corrected. But that was one of the concerns I had, is that the 4 medical declarations from healthcare providers that you 5 6 submitted consistently referred to these as being clearly 7 life-threatening and, therefore, falling within the affirmative defense. 8 9 MR. CHURCH: So just as one example, Your Honor, we 10 only submitted one declaration from a healthcare provider on 11 behalf of the State. This was at 66-1, declaration --12 THE COURT: Perhaps it was submitted by the 13 intervenor --14 MR. CHURCH: The legislature. THE COURT: But I'll let Mr. Stewart respond to that. 15 16 MR. CHURCH: I do want to make one clarification, 17 though, Your Honor. 18 We did point out that -- this would be from the 19 declaration of Kraig White, paragraph 4, and this is at page 4 20 as well. He, for instance, says: "It would be my good faith 2.1 medical opinion that termination of the pregnancy was necessary 22 to save the life of the pregnant woman." 23 So I believe that's consistent with --24 THE COURT: Okay. That's correct. That absolutely is

the language at issue here.

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MR. CHURCH: But we also understood, and my point,

Your Honor, was that the United States -- the federal

government's declarants certainly knew and made statements that

they were able to determine that a medical abortion was

necessary to save the life of the mother, which is the call that

18-622 imposes upon physicians.

Now, with respect to the chilling argument, our understanding of the chilling argument is that physicians — the United States asserts that physicians would feel chilled simply because there is an apparent conflict or an alleged conflict — excuse me — between 18-622 and the Treatment Act.

But we must remember that 18-622 applies in all contexts, not just in the Treatment Act context, but any facet of a physician's practice, you know, including practices outside of the Treatment Act.

And so making that decision that is placed upon physicians to determine whether an abortion is necessary to preserve the life of the pregnant woman is a call that they are going to have to make not just at the emergency room but also in their normal practice to the extent they believe an abortion is necessary in their good faith medical belief and judgment to preserve the life of the pregnant mother.

We would also note, at least for the chilling purposes, Your Honor, that there is just no direct conflict with any particular requirement of the Treatment Act.

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THE COURT: Well, let me ask a question about that.

And you are about out of the time that you have agreed was a portion of time. I'm going to actually have a question or two to follow up, so I think I will just turn your clock off while I ask those questions.

MR. CHURCH: I appreciate that, Your Honor.

THE COURT: You might not appreciate it when I'm done, but we'll see. I hope your answers will be enlightening because I've got a question that I think points out, at least in my mind, the challenge in how we apply this.

How do we get around the fact that the affirmative defense only deals with conducting an abortion necessary to prevent the death of the patient when the EMTALA talks about having injury to organs adversely affecting -- you know, serious impact upon health? I can't, off the top of my tongue, give you those three elements.

But isn't there just a total impossibility preemption because there is just complete conflict because there is no exception for anything short of an abortion necessary to prevent the death of the patient when EMTALA clearly says you have to be concerned about their health as well?

 $$\operatorname{MR}.$  CHURCH: Well, let me make two points in response to that, Your Honor.

First, I do want to look at the statutory text of the Treatment Act just to make sure we are on the same page as far

as the terms.

And Your Honor cited, I believe, first, the definition of "emergency medical condition," which, as we have all agreed, as provided by the text of the statute to mean "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 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Or there is another provision that applies with respect to a pregnant woman who is having contractions.

THE COURT: Yeah, right. So those were the three. That's exactly the three conditions under EMTALA that I can never rattle off, but you did a nice job of doing that.

MR. CHURCH: But I want to offer one more point, Your Honor, with respect to that.

When a patient is -- when a person goes to the emergency room, has a screening, and that screening determines that there is an emergency medical condition -- which is what we have been just discussing -- that is then the springboard or it starts the process that's required by 49 U.S.C. 1395dd(b)(1) -- well, correction -- well, I'm sorry, Your Honor. I apologize. It's within sub (b) sub (1) that the -- once there is an

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emergency medical condition that has been found, it is then up to the hospital, "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."

And the reason why I bring that up, Your Honor, is I want to make sure we're clear on the definition of stabilizing treatment, because stabilizing treatment under provision (e) sub -- it's going to be (e) sub (3) is treatment that is "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."

So I want to make sure, Your Honor, that, you know, stabilizing treatment is not necessarily a cure of an emergency medical condition, Your Honor. It is simply treatment that's necessary to assure that there is no material deterioration within a reasonable medical probability of whatever condition is there.

Now, Your Honor asked about what happens where an abortion is -- a provider determines that abortion is necessary not to prevent the death of a woman, but it would be necessary as some form of stabilizing treatment.

THE COURT: Well, not -- it would be necessary to protect her health, to protect her organs, to protect, you know,

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those three standards that EMTALA imposes. That's where my concern is.

In fact, let me -- I'm going to ask -- I've asked

Ms. Smith to stop the clock for a minute here. I don't want to
take up Mr. Stewart's time. I'm hopeful he appreciates that.

But here, you know, I've tried to think in my mind what kind of portrays where the conflict is. And I thought about, you know, maybe it's being someone who wishes they had been a law school professor, and so I came up with a hypothetical that law professors like to use to try to make points. And I'll throw that at you, and you can tell me how you would respond.

Let's say you're an attorney with a client who is an ER doctor. She calls somewhat in a frantic state because she has got a patient that she is now treating in a very difficult situation; let's say it's preeclampsia. They have tried to control it medically and have been unable to, and the accepted medical practice at that point is an abortion.

Basically, her blood pressure is completely out of control; and in her experience, if the abortion is not performed, there is at least a 50/50 likelihood that she will die.

She also indicates that she is completely risk averse and is not willing to take any chance that she will be prosecuted even though that she might be able to succeed on an

affirmative defense.

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So, as her attorney, do you advise her that she can perform the abortion under the statute without any risk of prosecution?

MR. CHURCH: Well, Your Honor, I appreciate the question.

And so with respect to that, just to make sure we're clear, that this would be a situation covered by the Treatment Act to begin with.

THE COURT: Yes. I should have predicated. Yes, absolutely.

MR. CHURCH: So with respect to that, Your Honor, and the current version of Idaho Code 18-622, I, as the lawyer, would advise that -- I would ask questions: Is this necessary to prevent the death of a pregnant woman?

THE COURT: Well, she said it's at least 50 percent. It's a 50/50 proposition.

MR. CHURCH: Well, Your Honor, but I would -- as the lawyer, I would point back to the fact that 18-622 contains no risk or no 50/50 risk requirement or no requirement that the death be imminent or some other temporal requirement. It simply applies where the abortion is necessary to save the life of the pregnant mother.

THE COURT: And she says: I can't answer that; I can just tell you it's 50/50.

MR. CHURCH: Well, then that physician, well, one, could also consider consulting not only with me but with other physicians, or --

THE COURT: She has got a patient that is in critical medical condition; she has to make a decision immediately as to what to do.

MR. CHURCH: Well, Your Honor, you know, as the attorney for the hospital, you can only advise on what the law is. And the law says, under 18-622, that she needs to determine in her good faith medical judgment whether the abortion is necessary to preserve the life of the pregnant mother.

THE COURT: And if she gets it wrong, she is prosecuted, charged, arrested, and has a chance to argue and prove to the jury that her judgment was right; the 50/50 is enough to say that it was necessary to prevent her death? Is that --

MR. CHURCH: I do want to quibble with one last aspect of your point there, Your Honor.

Remember, under 18-622, the affirmative defense that is offered is based on the physician's subjective good faith medical judgment. If the physician can testify and show that it was within her good faith medical judgment to perform the abortion and that the abortion was necessary to save the life of the pregnant woman, then that falls within the affirmative defense of Idaho Code 18-622.

THE COURT: And what if she says, you know, they think they can control it, but there still is a 5 percent chance that she will die. Does that change your advice to the doctor?

MR. CHURCH: No, Your Honor. Because, again, there is no -- not at least from the State's perspective, there is no probability or risk that is part of 18-622. 18-622 just requires that the physician make that determination of whether it's necessary to preserve the life of the pregnant woman.

THE COURT: All right. Well, then the same hypothetical, but she indicates that if the abortion is not performed, the patient will not die, but there is a 90 percent chance she will suffer a stroke, have permanent damage to her vital organs, such as her heart, her liver, or her kidneys.

What's your answer then?

MR. CHURCH: Well, Your Honor, it's the same answer in that you would have -- under Idaho law, the affirmative defense arises under 18-622 when the abortion is necessary to prevent the death of the pregnant woman.

THE COURT: So you would tell her she cannot perform that abortion, or she would be facing criminal liability?

MR. CHURCH: Your Honor, I would just be advising as to what the statute says, Your Honor.

But I would note for purposes of this case,

Your Honor, that because this is a facial challenge, there are

still circumstances where, you know, 18-622 and the Treatment

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Act can be applied. And that's a reason why we should deny the United States' requested preliminary injunction relief in this case.

THE COURT: Okay. So basically, as an attorney, you'd simply tell the doctor, your client: This is what the statute says, and I can't tell you whether you will be prosecuted or not, but the risk is that this is what the statute provides?

And I assume you would agree that in the last part of my hypothetical where there is no risk of death, but there is a substantial risk of serious impact upon her health -- organs failing, permanent damage to those organs, maybe a stroke -- that in that situation, the statute would not apply and would not provide an affirmative defense.

MR. CHURCH: Your Honor, I'm only bound by what 18-622 provides.

THE COURT: Okay. Well, that's why I'm asking. Do you agree that 18-622 would not provide an affirmative defense in that situation?

MR. CHURCH: If the -- if the physician cannot testify in her good faith medical belief that she believed the abortion was necessary to preserve or prevent the death of the pregnant woman, then the affirmative defense would be inapplicable in that case, Your Honor.

THE COURT: All right. And she would be subject to criminal prosecution and face a minimum two years in prison?

MR. CHURCH: Subject to what I have just said, yes, 1 2 Your Honor. 3 THE COURT: Okay. All right. Thank you. Anything else? I will let you make a few parting 4 shots before we hear from Mr. Stewart, if there is anything else 5 6 you want to add. 7 Counsel, I know the hypothetical -- I remember from law school that we sometimes think that professors are being 8 9 unfair, but usually they are doing it to try to point out kind 10 of where the cutting edge is. 11 And that's the reason I did that, is to try to see how 12 a real-life attorney dealing with a real-life doctor dealing with a real-life pregnant patient, how they are to confront the 13 14 statute in an emergency room setting. And that's why I asked 15 the questions that way. 16 You gave a very lawyerly response, which is: This is 17 what the statute provides and wouldn't provide guidance beyond 18 that. 19 But is that troublesome in terms of EMTALA compliance? 20 MR. CHURCH: I don't think so, Your Honor. Because, again, I'm not certain that there is a direct conflict here that 2.1 22 is presented. THE COURT: Even in the context where it's not 23 24 life-threatening? 25 MR. CHURCH: Well, even if there could be a conflict,

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         Your Honor, again, in the State's position, this is a facial
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         challenge.
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                   THE COURT: All right.
                   MR. CHURCH: And we would have to show -- the
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         United States would have to show that in all instances, 18-622
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 6
         conflicts with the Treatment Act.
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                   Our position is they clearly haven't shown that,
         Your Honor. And for these reasons, we would ask that you deny
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 9
         preliminary injunctive relief requested by the United States.
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                   THE COURT: Well, thank you.
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                   MR. CHURCH: Thank you, Your Honor.
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                   THE COURT: Thank you, Mr. Church.
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                   Mr. Stewart.
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                   MR. STEWART: Your Honor, Monte Stewart along with
15
         Daniel Bower representing the Idaho legislature.
16
                   Here is my answer to your hypothetical: That doctor
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         calls me from the emergency room or, more accurately, from an
18
         extension of the emergency room, which would be up in labor and
19
         delivery, which is where these emergencies really do play out.
20
                   And, yes, EMTALA does apply in labor and delivery;
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         it's not limited physically to the emergency room.
22
                   That doctor calls me and gives me the 50/50
23
         hypothetical. I tell her: You go right ahead, and you use your
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         best medical judgment, and you can do so without fear of
25
         prosecution.
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Now, I can do that and put my legal malpractice insurance policy on the line and do so without the slightest heartburn or without ever second-guessing myself.

I'm speaking to you as someone who has prosecuted cases in state court and as someone who, as an employee of the United States

Department of Justice, as the United States Attorney for the

District of Nevada, has prosecuted cases and knows how

prosecutors think: In the real world, there will not be a prosecution. And Grant Loebs certainly backs me up.

Now, you then try to -- you then moved to make the hypothetical more challenging where you eliminated the risk of death. And you, I think, were trying to use some language from EMTALA itself, from the definition of "emergency medical condition" -- "serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

Now, subpart (2) and subpart (3) -- I think I can help. And this is going to help through the remainder of the time you give me. May -- with the leave of the Court, may Mr. Bower pass out a packet to Court and counsel, law clerks, if that's okay, with just a few documents in it?

THE COURT: What is it you want the Court to look at?

MR. STEWART: The first document is actually the

Government's proposed preliminary injunction order. The second one is the page from EMTALA that I am referring to. And the

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         third document is an exercise I went through regarding the
         proper scope of any injunction if you decided to go in that
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 3
         direction.
                   And, of course, the legislature believes the only
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         proper order is motion denied, but I think it's helpful in this
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 6
         factual context to address that.
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                   THE COURT: Why don't you put that on the evidence
 8
         presenter.
 9
                   MR. STEWART: What's that?
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                   THE COURT: If you could just put that on the evidence
11
         presenter, it might be easier. We could possibly even -- I
12
         don't know if we can bring it on for those in the audience,
13
         but...
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                   MR. STEWART: Can you see this or just the audience?
15
                   THE COURT: I'm supposed to be able to see it.
16
                   Well, all right. Yeah, I can now. It's up on my
17
         screen. I don't know if we are able to show it to the --
18
                   MR. STEWART: Given my age, I'm low-tech. That's why
19
         I brought paper copies for everyone.
20
                   THE COURT: I am not low-tech, and I prefer -- okay.
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         I think we have got it. Go ahead.
22
                   MR. STEWART: Okay. Well, if you'll see here, subpart
23
         (2) and subpart (3) are the ones I just read to you. And that's
24
         what I heard you saying --
25
                   THE COURT: That's not precisely --
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MR. STEWART: -- in that second hypothetical. Is that 1 2 correct? 3 THE COURT: Well, I was not trying to capture it precisely, but that was the point. 4 MR. STEWART: But the general idea, yes. 5 6 I would give the same answer with the same absence of 7 any heartburn. THE COURT: So you are saying there is no risk of 8 9 prosecution --MR. STEWART: Because there is another affirmative 10 11 defense in the real world. And that is assuming -- and I'm not 12 conceding anything -- you have limited me to talk about the 13 actual conflict which is the fact-intense issue here. 14 talking only about that, I am honoring your directive to me. THE COURT: Okay. Well, I think what you're saying is 15 16 that prosecutors will not actually prosecute under these 17 circumstances. 18 MR. STEWART: Right, because there is an affirmative 19 defense under the Government's own position --20 THE COURT: Just a moment. Just a moment, 2.1 Mr. Stewart. 22 But there is not an affirmative defense as to the 23 three categories that we listed here, because the statute 24 doesn't provide an affirmative defense where it is just 25 health-threatening as opposed to necessary to prevent the death

of the mother.

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MR. STEWART: Yes. 622 doesn't provide it, but EMTALA does.

THE COURT: But that's the point, is EMTALA is in conflict with -- or at least the Government is arguing that EMTALA is in conflict with a federal statute which criminalizes providing an abortion as a medical treatment if it is not necessary to preserve the mother's life.

MR. STEWART: Exactly right.

Your Honor, let me step back and tell you that there is a gulf between Mr. Netter and Mr. Stewart. Mr. Netter's approach is highly conceptual, highly textual, highly abstract. Mr. Stewart's approach is real life, real world, and practical.

THE COURT: Well, isn't real world -- I noted that

Mr. Netter referred to the comment made during the debates that

led to the adoption of the Idaho abortion statute in which an

effort was made to apparently include some protection for the

situation where the pregnant patient's health is at risk.

And the response was: Well, in that situation, the right of the fetus should be primary.

Are you saying there are no prosecutors out of 44 counties in the state of Idaho that might not take that same position?

MR. STEWART: Let me take the easiest case first.

Idaho is capable of many things, but it is not capable

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of producing now or in the future a prosecuting attorney stupid enough to prosecute an ectopic pregnancy case. The first thing the doctor --

THE COURT: I didn't ask about an ectopic specifically.

Just generally, given the attitude or the expression of legislative intent which Mr. Netter referenced during his oral argument, are you saying there is no prosecutor, in the 44 counties in the state of Idaho, who would take the position that where it is only necessary to protect the health of the mother -- I keep using the word "mother" -- health of the pregnant patient, that should give way to the rights of the unborn fetus?

MR. STEWART: The answer to that, Your Honor, is that this legislation is designed to balance this state's determination of the moral value of the preborn child on one hand and the often weighty, weighty and even heart-wrenching interests of the mother -- I won't hesitate to use the word -- on the other hand. And this is where, in the exercise of its constitutional right, the State of Idaho has drawn the line.

What I'm trying to get across here, Your Honor -because you're being asked to issue an injunction that carves
back against Idaho's judgment and to do so on the basis of one
federal statute, EMTALA. And we have talked about the conflict.

It is a fact-intensive conflict. I would like to point out something extremely important, the single-most important thing I can say to you right now in the time given me.

If you will look at the EMTALA language that's up on the screen, you will see there is a subpart (1): "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."

There is congressional language expressing a congressional intent to protect and preserve the mother and the child equally -- not one above the other, equally.

Why I have that in yellow and why this is the most important thing I can tell you is because of the language the Department of Justice wants you to use in any preliminary injunction order.

They have used -- and this is the first document in the packet. They have used -- after distorting the language of subpart (1), they have used the subpart (1) language in the proposed order. They even preserve the subpart (1) numeral, but they don't quote it truthfully and fully and honestly, "placing the health of a pregnant patient in serious jeopardy."

In other words, Your Honor, please, they have taken congressional language, the purpose -- the clear meaning of which, the clear purpose and intent of which is to protect the unborn child from serious injury, serious jeopardy, serious

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health problem. And they are writing that language after they have taken out any reference which they never gave you anywhere in their papers -- any reference to the "unborn child." They are using that language --

THE COURT: Just a moment, Mr. Stewart. Just a moment.

The conflict here is between a state statute

permitting an abortion -- excuse me -- criminalizing an abortion

even where the abortion would be necessary to preserve the

health and ensure no injury to -- permanent injury to organs,

et cetera. How or why should the requested relief in any way

reflect a concern for the health of the unborn fetus? Because

we're talking about an abortion where the choice has been made

where there is no balancing at that point.

MR. STEWART: Because your authority extends to the boundary of the conflict and no further. You can enjoin 622 to the extent of a conflict; perhaps only conceptual, hypothetical, abstract conflict, because we have shown there is no actual one. But that's the limit of your authority to enjoin enforcement and operation of 622.

So what is the boundary of that conflict? It's discernment by 622 on one hand but certainly by EMTALA on the other hand. You can't say that 622, with its intent to protect the life of the child, conflicts with subpart (1), which is Congress's intent to protect the child.

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You don't have the "unborn child" reference in subpart (2) and subpart (3). And that's why it would be entirely wrong to use subpart (1) language in any preliminary injunction order, because you're going outside the scope of what Congress intended.

Why is the Government trying to shoehorn in this subpart (1) language? Well, I submit, in all due respect, that it's to keep the administration's political promise to push back against *Dobbs* and to restore, to the extent possible, under the powers of the executive branch.

I would ask leave of the Court to submit a redline -it's actually blue on this document --

THE COURT: Counsel, your time is almost up.

 $$\operatorname{MR}.$  STEWART: I understand that. This is the most important thing I can do.

THE COURT: All right. I'm just letting you know. So go ahead.

MR. STEWART: Yes. Thank you.

-- to submit a proposed what we call a fallback order -- we are not consenting or agreeing or conceding anything -- but that carefully, carefully defines what it is that is being enjoined and carefully limits the injunction to its only proper basis, which is the actual conflict based on EMTALA.

And that's part of that packet that I requested leave

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to submit. We can submit it after the hearing is over if you
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 2
         prefer.
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                   THE COURT: Well, the concern during oral argument is
         the Government needs a chance to respond. So I don't know -- is
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         there a reason why it couldn't have been submitted in advance?
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 6
                   MR. STEWART: Well, it's only because we only very
 7
         recently realized what the Government was doing with this
         subpart (1).
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 9
                   THE COURT: Well, I don't think there is any secret
10
         here --
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                   MR. STEWART: Misuse of subpart (1) --
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                   THE COURT: Just a moment, Mr. Stewart.
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                   There is no secret about it. You put up the
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         complaint, or at least the proposed order. I don't think there
15
         is too much surprise about that.
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                   What is it you want the Court to consider?
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                   MR. STEWART: A blue-line of the Government's proposal
18
         order which --
19
                   THE COURT: Well, you're --
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                   MR. STEWART: -- puts in the proper limitations that
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         it does not contain.
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                   THE COURT: You're over time now, but let me just ask
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         it this way: So are you saying that because of the language in
24
         EMTALA at subparagraph (1) that you cite, that this indicates
25
         that Congress has indicated that no abortion can be performed
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because that would, by definition, be inimical to the life and 1 2 health of the fetus? 3 MR. STEWART: What I'm saying to the very best of my ability, Your Honor, is that that language, subpart (1) 4 language, cannot be used to increase the risk of jeopardy to the 5 6 health of the unborn child because its purpose is to do the 7 opposite. THE COURT: So, really, you are saying that if we have 8 9 a situation where an abortion is necessary to preserve the 10 health of the mother, then, in that situation, EMTALA would 11 still preclude that abortion because it does not take into 12 account the life of the unborn fetus? 13 MR. STEWART: What I'm saying -- yes. Well, let me 14 say it this way: Subpart (2) and subpart (3) set a standard. 15 By the way, the Fetal Heartbeat Act echos sub (2) and 16 sub (3). That's why the Government didn't challenge it, even 17 though it is now in effect and has criminal provisions equally onerous. 18 19 THE COURT: But it doesn't -- as I suggested with 20 Mr. Church, it does not supersede 622. 622 is still and will be 2.1 in effect come Thursday. 22 MR. STEWART: No, it will not be in effect if you 23 enjoin its operation. 24 THE COURT: No, no, no. Without an injunction. 25 mean, I thought that was obvious from my question.

1 MR. STEWART: Right, right, right. But, of course, 2 what I'm saying is --3 THE COURT: No, no. My question is: It will still be in effect; the fetal heartbeat law will not supersede or in any 4 5 way affect the Section 622 coming into effect on Thursday? 6 MR. STEWART: That's correct. The superseding 7 language is actually in the Fetal Heartbeat Act itself, which was enacted later, a year later than the --8 9 THE COURT: No. You answered my question. 10 MR. STEWART: Yes. 11 THE COURT: You're well over your time. If you want 12 to submit it, I'll look at -- I'll give you a minute to very 13 quickly summarize the argument you are going to make with this, 14 and then I'll --15 Mr. Netter, if you, after looking at it, feel the need 16 to respond, I may give you a chance to submit a very short, 17 maybe one- or two-page response since you have not seen this in 18 advance. Or if you think you can look at it quickly and 19 incorporate that into your argument, you can do that as well. 20 MR. NETTER: Thank you, Your Honor. 21 THE COURT: Mr. Stewart, just a minute to wrap up 22 before I turn the time back to Mr. Netter. 23 MR. STEWART: In the real world, there is no conflict. 24 I'm not disputing, Your Honor, the conceptual textual conflicts, 25 but what matters is what happens in the real world.

And I believe the factual demonstration is very strong that there is no actual conflict between the operation of 622 and the operation, within its intended and proper scope, of the -- of the EMTALA language, especially because -- and this is my last sentence -- my doctors whom I respect greatly tell me that they have never encountered a case falling within subpart (2) and subpart (3) where the health of the mother -- excuse me -- the life of the mother was not in danger and threatened and likely to occur.

The Government has not given you one concrete example of that --

THE COURT: Did you read Dr. Corrigan's --

MR. STEWART: Yes.

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-- other than -- other than ectopic pregnancies.

And you have known our position for weeks. The legislature had no intent, because as our doctors told us -- one of the first things they told us: What? No. An ectopic pregnancy is not an abortion. Why? Because it will never result in a live birth, and it will always put --

THE COURT: Excuse me, Counsel. Counsel, just a moment. That's not the definition of "pregnancy," nor is it the definition of "abortion" under the statute.

MR. STEWART: Well, again -- again, the conceptual as opposed to the real world and the practical. My clients are real-world, practical folks.

1 THE COURT: All right. Thank you. 2 Mr. Netter. 3 MR. NETTER: Your Honor, let me start with a quick administrative note. 4 5 THE COURT: Yes. 6 MR. NETTER: To make it easier for the Court to locate 7 the representation by the State in the Idaho Supreme Court proceedings as to what the affirmative defense means, I want to 8 9 provide a more specific citation because the filings are a bit 10 difficult to navigate. It's in Case No. 49817. It is a document entitled 11 12 "Respondents' Response to Order Setting Hearing," and it's at 13 page 14. 14 THE COURT: I would note I understood Mr. Church is 15 not in any way running away from that statement. I think he was 16 pretty clear that the language necessary to prevent the death of 17 the pregnant patient means what it says and says what it means. 18 And I appreciate his candor that -- I don't think he 19 ran away from that, and I think he apparently took roughly the 20 same position that his colleague in the Attorney General's 2.1 Office took before the Idaho Supreme Court. But I appreciate 22 that, and I will look at that. 23 Go ahead. 24 MR. NETTER: I don't disagree, Your Honor. I also 25 understood Mr. Church to be attempting to faithfully interpret

the statutory text.

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My only point of departure would be that Mr. Church said that he was not troubled in the circumstance that the 50/50 hypothetical with the prospect that there could be a criminal violation or criminal prosecution; whereas with reference to EMTALA, I see that as deeply problematic and, from a moral standpoint, extremely objectionable.

Now, the State's primary arguments here seem to rest on the *Salerno* issues as to whether or not, as a technical matter, the challenge presented by the United States is a facial challenge.

To be clear, this is not a facial challenge that has been filed by the United States. A facial challenge would be if we had said: Here is one defect we have identified; and as a result, the entire statute falls.

Our challenge is tailored to the circumstances in which EMTALA applies. So every time EMTALA mandates care, Idaho law must yield.

Now, I thought I understood Mr. Church to be saying also that perhaps it's okay, that maybe this can be litigated later, or perhaps there is, like, an affirmative defense that can be raised in criminal proceedings stemming from EMTALA. And that last point might have been from Mr. Stewart.

So I want to be clear on this: That the injury to the United States takes place sooner. That the issue here is, as

the physicians have told us in their declarations, there will be hesitancy to comply with federal law.

The federal interest here is in ensuring that the benefit of the bargain -- the federal law -- in ensuring that the emergency care that is prescribed by EMTALA is actually delivered.

And if there are circumstances in which a doctor hesitates, in which a doctor has to call the lawyers and get a legal opinion because it seems like Idaho law might be violated or has to speak with Mr. Stewart about his sense of whether, despite the statutory text the prosecutor is going to bring the charges, this is all in conflict with EMTALA and federal law, which requires the care to be offered at the point where it's necessary.

Now, Mr. Stewart said in this context that Idaho has drawn its line. And I want to be clear that our position is that Idaho doesn't get to draw a line that conflicts with EMTALA.

Federal law has prescribed a standard to the extent of any direct conflict -- which, in this context, means impossibility or obstacle preemption -- federal law governs.

And Idaho doesn't have the prerogative, under the supremacy clause of the U.S. Constitution, to draw its own distinct line.

So Mr. Stewart just brought up the statutory language about "unborn child." And I'll say first that I don't believe

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that this issue is properly before the Court. It was not raised in the papers. Indeed, both the State and the legislature indicated that they agreed that there were circumstances under which EMTALA would require abortions as a stabilizing treatment.

I understood Mr. Stewart's argument to be, because of this "unborn child" language in the statute that, in fact, the opposite is true. And that position has surely been forfeited.

In any event, that interpretation of the statute, the interpretation of the statute that I think Mr. Stewart was intimating at, is just not correct.

The "unborn child" language did not appear in EMTALA as it was originally adopted. It was incorporated through an amendment that was adopted in 1989. There is nothing in the text or in the statutory history that suggests that Congress was trying to prohibit emergency abortions in some extremely roundabout fashion.

Instead, it appears that it occurred to somebody that there could be an emergency condition pertaining only to a fetus; and that if a pregnant individual appeared at a hospital and she was herself healthy but had a fetal condition, that the hospital should be providing treatment under the same circumstances.

Now, none of this suggests that emergency abortions have somehow become unlawful or unnecessary under EMTALA.

Indeed, it is meaningful that the requirement under EMTALA is

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not for the doctor to actually perform a particular treatment but for the hospital to offer the treatment and to discuss the pros and cons, the risks and the benefits of the treatment. And if after that discussion of the risks and benefits, the patient refuses to provide informed consent for the procedure, then that's the patient's prerogative.

And we have seen in some of the declarations that it does sometimes happen; that when doctors make recommendations about medical care, patients think otherwise.

There are some other indications, too, post the 1989 amendment, that suggest that Mr. Stewart's potential interpretation of the "unborn child" language doesn't work.

We noted in our opening brief that Congressman Weldon, the author of the Weldon Amendment -- which is designed to protect from discrimination institutions that decline to provide abortions -- in the legislative history of the Weldon Amendment in 2005, Representative Weldon was asked: Why doesn't your amendment mean that when women are experiencing life-threatening conditions, that they will be effectively dying on the operating table?

And his response, coming from the perspective of somebody who was trying to empower institutions that decline to provide abortions, was that EMTALA would govern in those circumstances and that nothing in his amendment would preclude the provision of that lifesaving care under federal law.

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Likewise, through the Affordable Care Act in 2010, 42 U.S.C. 18023, Congress provided circumstances under which a state can exclude abortions from the health plans that are offered on the marketplace in the state. And in so doing, Congress explicitly recognized that nothing in the Affordable Care Act was designed to overcome the provisions of EMTALA in that context.

Mr. Church also brought up the heartbeat law. He suggested that we had endorsed the exception to the heartbeat law. And I just want to make clear that we haven't done so.

The fact that we haven't expressly challenged the exception in the heartbeat law doesn't mean that we have blessed that particular formulation, particularly in light of the fact that, under our reading of 18-8804 and -8805, that law is effectively to expire later this week.

I was having a hard time understanding if Mr. Church was suggesting that the heartbeat law could survive to the extent this Court were to enjoin the Total Abortion Ban.

We certainly don't read 18-8804 and 18-8805 to provide that avenue. It says if the Total Abortion Ban becomes enforceable -- which it would even if it's enjoined to the extent that it's in conflict with federal law -- that the heartbeat law would no longer be in effect.

Your Honor, I want to go back to the point that Mr. Stewart made suggesting that the statutory text doesn't

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matter here, effectively, because he knows what prosecutors think.

I have no way to gauge whether or not he truly understands how the prosecutors in each county of this state think or how the voters are going to think about prosecutors they are going to elect in the future or how members of a grand jury might think before taking a complaint to a magistrate.

But the question here is how doctors are going to evaluate the statute. And we submitted in the declarations explanations from the doctors about the horrifying situation that they anticipate will result from the full implementation of the Total Abortion Ban.

The other point about Mr. Stewart's representation and the practicalities matter is the Court should take this as an enormous concession. If the legislature, and potentially the State, are taking the position that the text of the statute isn't real, then that means the text of the statute isn't lawful.

And the role of a court of law in that context is to enjoin the impermissible operation of a law which will cause drastic effects and dramatic consequences for pregnant individuals in the state of Idaho and for physicians and for medical providers.

So unless the Court has further questions -- THE COURT: No.

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MR. NETTER: -- we would ask the Court to enter the preliminary relief requested in our motion.

THE COURT: Thank you, Mr. Netter.

Counsel, I intend to issue a written decision in this matter. My best guess is we won't have it done until Wednesday, possibly tomorrow, but our plan is no later than Wednesday since the law takes effect on Thursday.

I will offer just one or two observations. I am having a hard time seeing how this is an as-applied challenge where there is clearly a very narrow and, as I think, frankly, Mr. Stewart has argued, a very rare, in his view, perhaps nonexistent threat, but it's certainly in very limited circumstances where the abortion statute would be precluded.

I hope I made clear: It seems to me it's clearly an as-applied challenge, and I have a hard time seeing how this could be a facial challenge.

Another thought that I think I do want to observe.

Mr. Stewart has made a great deal that we should focus on the real-world events and not on the text, the conceptual language of the statute.

The concern is, of course, that real-world events are very hard to predict. The text of the statute is very easy to read and understand. And I think the case law is absolutely clear that it is the text that matters and that we don't -- judges are not issued some kind of a crystal ball when

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they're appointed to the bench that allows them to see what the facts are, but we are generally trained in interpreting the case, the statutory language.

And I think this case kind of underscores why the case law is clear that we do need to look at the text in determining whether there is a conflict between federal law and state law.

Simply put, doctors in emergency rooms and labor and delivery rooms around this state are going to be forced to navigate their way through this conflict between the abortion statute and EMTALA. I think it is not much comfort to a doctor in that there is a sitting prosecutor who they think will not enforce it, but no one knows for sure.

And importantly, the text matters in terms of impacting the decisions made by those doctors when they confront a life-or-death situation involving a pregnancy that has gone horribly wrong.

So I think in terms of determining preemption, we have to look at the statute. And I have a very hard time seeing how we can compare the abortion statute as we think it may be applied to what EMTALA requires when we certainly can't rule out the possibility that it will, indeed, be enforced.

Indeed, the legislature would not have adopted the law unless they intended that it would be enforced according to the exact terms that they set forth. I don't think our legislature ever intends a law thinking that it will not be enforced

1 according to its terms. And that's why I think the law is clear that that's 2 3 what we look at; we look at the statutory language. We don't 4 quess about what a prosecutor will or won't do. And I think 5 I'll just leave it at that. So there are some other concerns I've got. I've tried 6 7 to point those out at the outset in my questioning. We will 8 issue a written decision. I think, without any doubt, it will 9 be filed no later than Wednesday so we have a clear guidance one 10 way or the other before the statute takes effect. 11 Is there anything else, Counsel? 12 MR. NETTER: No, Your Honor. 13 MR. STEWART: No, Your Honor. 14 MR. CHURCH: Nothing from the State, Your Honor. 15 THE COURT: Then we'll be in recess. 16 (Proceedings concluded at 10:50 a.m.) 17 18 19 20 21 22 23 2.4 25

1	REPORTER'S CERTIFICATE
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4	I, TAMARA I. HOHENLEITNER, CSR, RPR, CRR, certify that
5	the foregoing is a correct transcript of proceedings in the
6	above-entitled matter.
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14	/s/ Tamara I. Hohenleitner 08/24/2022
15	TAMARA I. HOHENLEITNER, CSR, RPR, CRR Date
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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 1 of 292

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

# STATE OF IDAHO'S EXCERPTS OF RECORD Volume 3 of 3

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#### UNITED STATES DISTRICT COURT

#### DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Case No. 1:22-cv-00329-BLW

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

SUPPLEMENTAL BRIEF SUPPORTING STATE OF IDAHO'S MOTION FOR RECONSIDERATION [Dkt. 101]

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Rules
Idaho Appellate Rule 38(b)

After this Court entered its preliminary injunction on August 24, 2022, Dkt. 95—and after the State of Idaho filed its initial motion for reconsideration, Dkt. 101-1—the Idaho Supreme Court issued a decision holding that Idaho's general abortion ban does not violate the Idaho Constitution. *Planned Parenthood Great N.W., Haw., Alaska, Ind., Ky. v. State of Idaho*, Nos. 49615, 49817, 49899, 2023 WL 110626 (Idaho 2023); Dkt. 119-2 at 3.<sup>1</sup> In reaching that decision, the Idaho Supreme Court also defined the scope of Idaho Code § 18-622 in at least two ways that conflict with this Court's interpretation of that law. *First*, the Idaho Supreme Court held that Idaho Code § 18-622 "does not require *objective* certainty" nor a "medical consensus" nor "a particular level of immediacy, before the abortion can be 'necessary" to prevent a pregnant woman's death. Dkt. 119-2 at 89-90; *cf.* Dkt. 95 at 27-29. *Second*, the Idaho Supreme Court held that ectopic and non-viable pregnancies "do not fall within [the] definition" of "abortion[s] as defined in [Title 18, Chapter 6]." Dkt. 119-2 at 88; *cf.* Dkt. 95 at 22-23.

These aspects of the Idaho Supreme Court's recent decision are binding on this Court. Whole Women's Health v. Jackson, 142 S. Ct. 522, 536 (2021) (plurality opinion of Gorsuch, J., in part II-C) (citing R.R. Comm'n of Tex. v. Pullman Co., 312 U.S. 496, 500 (1941)). Yet in its preliminary injunction decision, this Court relied on its own interpretation of Idaho Code § 18-622, which is now in conflict with the Idaho Supreme Court's binding decision. Under what is now known to be the authoritative interpretation of Idaho law, this Court's preliminary injunction decision would come out differently. The affirmative defense made available to physicians in Idaho Code § 18-622 does not conflict with EMTALA because it does not require a "medically impossible" determination that a pregnant woman is certain to die without an abortion, Dkt. 95 at 29, nor does it promote "delays" or "worsened patient outcomes"

<sup>&</sup>lt;sup>1</sup> Further citations will be to the slip opinion filed at Dkt. 119-2. That opinion is now final. *See* Idaho Appellate Rule 38(b); Request for Judicial Notice.

by encouraging physicians to wait to provide care until a pregnant woman is "nearer and nearer to death." *Id.* at 32. Nor does Idaho law prevent a physician from treating a woman presenting with an ectopic or non-viable pregnancy in an emergency setting, since the treatment for those medical emergencies does not meet the definition of an "abortion" under Idaho law. Dkt. 95 at 7-8, 22-23. Accordingly, in light of the Idaho Supreme Court's recent decision, there is no conflict between Idaho Code § 18-622 and EMTALA.

The State continues to believe that this Court should reconsider its preliminary injunction decision for the reasons set out in its motion for reconsideration. Dkt. 101-1. But in addition, because this Court's preliminary injunction decision depends on an interpretation of Idaho law that the Idaho Supreme Court has now rejected, this Court should grant the State's motion for reconsideration and deny the United States' motion for a preliminary injunction.

#### **DISCUSSION**

A. This Court's interpretation of the affirmative defense as being ambiguous and requiring physicians to make "inscrutable" decisions regarding "imminency of death" is simply incorrect.

This Court's understanding of the "necessary to prevent the death of the pregnant woman" affirmative defense within Idaho Code § 18-622 is no longer supportable in light of the Idaho Supreme Court's definitive interpretation of state law. This Court found fault with the affirmative defense because it thought it lacked clarity due to "ambiguous language and the complex realities of medical judgments." Dkt. 95 at 27. In this Court's view, the affirmative defense would require a physician to determine "how imminent a patient's death must [be] before an abortion is necessary"—an "inscrutable" decision. *Id.* The Court found support for its view, not in the text of the statute, but from statements offered by doctors put forward by the federal government; it believed that the affirmative defense required physicians to

"know the imminency of death" in order to rely on the defense. *Id.* at 28. The Court also concluded that the affirmative defense required physicians to make an "often 'medically impossible' determination that 'death [i]s the guaranteed outcome." *Id.* at 29 (citations omitted).

But the Idaho Supreme Court understood the affirmative defense differently. The affirmative defense provides wide latitude for a physician's "good faith medical judgment" on whether the abortion is "necessary to prevent the death of the pregnant woman" based on the facts known to the physician at the time. Dkt. 119-2 at 89. A physician's subjective judgment is what matters. *Id.* Indeed, the defense "does not require *objective* certainty." *Id.* It does not require "a particular level of immediacy, before the abortion can be 'necessary." *Id.* Instead, Idaho Code § 18-622 "uses broad language to allow for the 'clinical judgment that physicians are routinely called upon to make for proper treatment of their patients." *Id.* (citing *Spears v. State*, 278 So. 2d 443, 445 (Miss. 1973)). "A 'medical consensus' on what is 'necessary' to prevent the death of the woman when it comes to abortion is not required." *Id.* at 90.

Not only is there no "immediacy" requirement in the affirmative defense, there is also no "certain percent chance' requirement that the death will occur." *Id.* In fact, the affirmative defense was written broadly; the Idaho Supreme Court rejected an argument that the defense should have more guidelines. Those would "only necessarily *limit* the subjective nature of the affirmative defense." *Id.* Plus, as the supreme court noted, the petitioners' challenge to the "necessary to prevent the death of the pregnant woman" "improperly pluck[ed] the phrase from the sentence that gives it broad meaning." *Id.* The court also noted that adding factors such as immediacy and certain percent chance of death would add objective components to a subjective defense, removing the "wide room for the physician's 'good faith medical judgment' on whether the abortion was 'necessary to prevent the death of the pregnant woman." *Id.* at 89, 90-91.

The Idaho Supreme Court's decision renders essential parts of this Court's preliminary injunction order unsupportable, and as a result, this Court should deny the preliminary injunction that the United States seeks.

First, this Court's interpretation of Idaho Code § 18-622 and the affirmative defense is simply no longer supportable. A doctor need not make a determination of imminency of death in order to rely upon the affirmative defense. Contrast Dkt. 95 at 27, 28. There need not be a certain percent chance of death either. Contrast id. at 28-30. Death need not be an objectively "guaranteed outcome." Contrast id. at 29 (citation omitted). Nor is the "clinical judgment that physicians are routinely called upon to make for proper treatment of their patients" a "medically impossible" determination. Contrast id. (citation omitted).

The affirmative defense has a core of circumstances "that a person of ordinary intelligence could unquestionably understand when it comes to whether his or her conduct satisfies the [] affirmative defense." Dkt. 119-2 at 90. It "includes every situation where, in the physician's good faith medical judgment, an abortion was 'necessary' to prevent the death of the pregnant woman." *Id.* (citation omitted). Contrary to this Court's understanding, the defense is not ambiguous, its required decision is not "uncertain," and it certainly is not an "empty promise." Dkt. 95 at 29.

Second, this Court's analysis of obstacle preemption regarding the affirmative defense, Dkt. 95 at 26-31, has been upended. The Court built its analysis upon "[t]he uncertain scope" of the defense which led the Court to conclude the law would deter abortions. Id. at 27. It began by examining what a physician would need to prove to rely on the affirmative defense. Id. After providing an example based upon its

<sup>&</sup>lt;sup>2</sup> As the State also noted in its motion for reconsideration, the Court's obstacle analysis got off on the wrong footing by assigning a different purpose to EMTALA than its recognized anti-patient-dumping purpose. Dkt. 101-1 at 11-13. Idaho's regulation of abortion certainly does not encourage the dumping of patients. Instead, Idaho encourages the protection of prenatal life.

interpretation of the defense, the Court went on to cite the federal government's physician's statements. *Id.* at 28-29. The Court cited statements from Drs. Cooper and Corrigan that were based upon imminency of death, and Dr. Corrigan who discussed predicting with certainty an outcome. *Id.* Dr. Fleisher's statement cited by the Court saw the necessary-to-prevent-the-death standard as not useful, even though the Idaho Supreme Court found it to be an act of routine clinical judgment. *Id.* at 29 (also citing Dr. Seyb's declaration).

Likewise, later statements cited by the Court from Dr. Corrigan, an amicus brief, and Dr. Fleisher, contending that the statute required a medically impossible decision that death was the guaranteed outcome, and that death must be a certainty, have been proven incorrect by the Idaho Supreme Court's interpretation of Idaho Code § 18-622. Drs. Cooper, Corrigan, and Fleisher, all had incorrect understandings of the law, and these misunderstandings certainly colored other statements made by them. *E.g.*, Dkt. 86-3 (Dr. Corrigan Suppl. Decl.) ¶ 10 (understanding Idaho law to require risk-based-percentage analysis), Dkt. 86-5 (Dr. Cooper Suppl. Decl.) ¶ 2 (understanding Idaho law to require death be "imminent"), Dkt. 86-2 (Dr. Fleisher Suppl. Decl.) ¶ 4 (understanding Idaho law to require "a certainty (or at least very high probability) of death"); *see also* Dkt. 86-4 (Dr. Huntsberger Decl.) ¶ 12 ("If we must wait until a patient's death is imminent . . . ."), Dkt. 17-8 (Dr. Seyb Decl.) ¶ 13.

Third, this Court's remaining obstacle preemption analysis, Dkt. 95 at 31-35, was based upon the supposition that providers would delay providing an abortion until death was imminent or more certain to occur—what the Court referred to as "the blurry line" of the defense. Id. at 32. Yet, the Idaho Supreme Court's interpretation of Idaho Code § 18-622 and the "necessary to prevent the death" phrase undermines this analysis and the basis for the statements provided by the federal government's doctors. Idaho's law does not require pregnant women "get nearer and nearer to death." Id. Instead, Idaho's law "leaves wide room for the physician's 'good

faith medical judgment," relies on routine clinical judgment, and provides that "core of circumstances' that a person of ordinary intelligence could unquestionably understand when it comes to whether his or her conduct satisfies the above affirmative defense requirement." Dkt. 119-2 at 89, 90. Here, the Court's analysis of "delays" and "worsened patient outcomes" was based upon a misunderstanding of the affirmative defense in Idaho Code § 18-622. Dkt. 95 at 33. Moreover, the Court's speculative concern that it would be more difficult to recruit OB/GYNs was also based on a misinterpretation of the law, which as now interpreted by the Idaho Supreme Court, alleviates the concerns of the Court. *Id.* at 34.

Fourth, this Court's impossibility preemption analysis, Dkt. 95 at 19-24, concluded it was impossible for a physician to comply both with EMTALA and Idaho's law. The State has already explained why this is not the case because "there is no direct conflict between the state law defining the bounds of care that can be provided and a requirement of EMTALA to provide stabilizing treatment within those bounds." Dkt. 101-1 at 9-13. The impossibility preemption analysis also relied on an incorrect understanding of the affirmative defense, finding that "the patient's death must be imminent or certain absent an abortion." Dkt. 95 at 21. Again, this understanding is simply insupportable under the Idaho Supreme Court's interpretation discussed above. Additionally, the impossibility preemption analysis faulted the defense for having a scope that "is tremendously ambiguous" and relied on the interpretation of the defense that the Court discussed in its obstacle preemption analysis—which, as shown above, was faulty. *Id*.

In sum, the Idaho Supreme Court's analysis of Idaho Code § 18-622 and its affirmative defenses undermines this Court's interpretation of the statute, upends this Court's obstacle preemption analysis, and highlights faults in this Court's impossibility preemption analysis. For these reasons, and those identified in the initial motion for reconsideration, Dkt. 101, this Court should reconsider its

preliminary injunction order and deny the United States' motion for a preliminary injunction.

# B. Termination of ectopic pregnancies and other non-viable pregnancies are not abortions.

The Idaho Supreme Court's opinion also addressed the scope of Idaho Code § 18-622, and its conclusion is contrary to this Court's. This change in the controlling law is grounds for reconsideration and reversing its decision. Sch. Dist. No. 1J, Multnomah Cnty., Or. v. ACandS, Inc., 5 F.3d 1255, 1263 (9th Cir. 1993). In its opinion, the Idaho Supreme Court considered if Idaho Code § 18-622 applied and imposed criminal penalties on terminating all pregnancies. Dkt. 119-2 at 87-89. Applying a limited judicial construction, the Idaho Supreme Court determined that ectopic and non-viable pregnancies "do not fall within [the] definition" of "abortion[s] as defined in [Title 18, Chapter 6]." Id. at 88 (second and third alterations in original). For ectopic pregnancies, the Idaho Supreme Court found that this was "[c]onsistent with the legislature's goal of protecting prenatal fetal life at all stages of development where there is some chance of survival outside the womb." Id. As for non-viable pregnancies, the court explained in those situations "where the unborn child is no longer developing" and as such terminating those "are plainly not within the definition of 'abortion." Id.

The Idaho Supreme Court has applied a limiting judicial construction to the relevant definitions and Idaho Code § 18-622 and held that termination of ectopic pregnancies and of non-viable pregnancies are not abortions. The Idaho Supreme Court's post-preliminary-injunction holding is now binding. *See* Dkt. 121 at 4.

This Court's preliminary injunction order highlighted an ectopic pregnancy as an emergency medical condition, Dkt. 95 at 7-8, and faulted the Legislature's now-validated position that the termination of an ectopic pregnancy was not an abortion, *id.* at 22-23. This of course impacts the analysis of whether there is any conflict

between EMTALA and Idaho Code § 18-622, since a prime example from the Court is now—as a matter of law—not an abortion. (Of course, the State's position is that the regulation of abortion is not in conflict with EMTALA—state law can define the bounds of care that can be provided, while EMTALA can require hospitals to deliver treatment within those bounds. *See*, *e.g.*, Dkt. 101-1 at 3-6, 9-13.)

The impact extends beyond this Court's preliminary injunction order, however. The federal government relied on its example of ectopic pregnancies in its complaint and its preliminary injunction briefing. Dkt. 1 at 2, 7; Dkt. 17-1 at 2, 9, 10, 18; Dkt. 86 at 8-10, 16; see also Dkt. 106 at 18. Then the federal government's doctors relied on the erroneous interpretation of Idaho Code § 18-622 in providing their testimony regarding ectopic pregnancy. E.g., Dkt. 17-3 (Dr. Fleisher) ¶¶ 13-14; Dkt. 86-4 (Dr. Huntsberger) ¶¶ 9-13, 16. As such, a significant basis for the federal government's concern no longer exists—though, again, the State's position is that its regulation of abortion does not conflict with EMTALA.

### CONCLUSION

The Idaho Supreme Court's decision is a change in the controlling law. Its interpretation of Idaho Code § 18-622 and the affirmative defenses shows not only that the Court's interpretation of the law was wrong, but also that the analysis of preemption was flawed. Second, the Court's holding regarding ectopic pregnancies (and any other non-viable pregnancies) is now unsupported. These two reasons, which supplement those identified by the State in its earlier filed motion for reconsideration, are reasons to reconsider the preliminary injunction. Upon

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reconsideration, the federal government's preliminary injunction motion should be denied.

DATED: February 6, 2023.

STATE OF IDAHO OFFICE OF THE ATTORNEY GENERAL

By: /s/ Steven L. Olsen
STEVEN L. OLSEN
Deputy Attorney General

### CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 6th day of February, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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### UNITED STATES DISTRICT COURT

### DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Case No. 1:22-cv-329

D1 : .:

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95)

The State of Idaho moves the Court to reconsider its preliminary injunction and Memorandum Decision and Order, Dkt. 95, vacate the preliminary injunction, and on reconsideration deny the United States' Motion for a Preliminary Injunction, Dkt. 17. This motion for reconsideration is brought under Federal Rule of Civil Procedure 59(e). *See Credit Suisse First Boston Corp. v. Grunwald*, 400 F.3d 1119, 1123-24 (9th Cir. 2005). A Memorandum in Support

STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95) - 1

of State of Idaho's Motion to Reconsider Preliminary Injunction (Dkt. 95) accompanies this motion.

DATED this 21st day of September, 2022.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

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### UNITED STATES DISTRICT COURT

## DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-329

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### INTRODUCTION

This case is not about denying necessary medical care to save the lives of women. This case is about preserving for the State its sovereign power to regulate abortions within its boundaries. The Court erred when it found that Idaho Code § 18-622 directly conflicted with and was preempted by the Emergency Medical Treatment and Labor Act (EMTALA). The Court's order misinterpreted both the relevant state and federal statutes and, in so doing, created a nonexistent conflict that has significant federalism and state sovereignty concerns. After *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), states have the power to regulate, and even prohibit, abortions—EMTALA, a statute that was intended to ensure that all people receive emergency medical care regardless of ability to pay, did not suddenly take on new form to federalize abortion when *Roe v. Wade* was reversed. *Roe v. Wade*, 410 U.S. 113 (1973). The Court's interpretation of EMTALA unconstitutionally hijacks Idaho's power to regulate abortion and is the product of clear error. Moreover, the Court's injunction is internally inconsistent and failed to hold the United States to its heavy burden on a motion for preliminary injunction. Idaho asks that this Court reconsider its decision, vacate the preliminary injunction, and deny upon reconsideration the United States' request for a preliminary injunction.

#### LEGAL STANDARD

A motion to reconsider is appropriate where "the court has misapprehended the facts, a party's position, or the controlling law." *Nelson v. City of Albuquerque*, 921 F.3d 925, 929 (10th Cir. 2019) (citation omitted). A motion to reconsider should be granted "if the district court (1) is presented with newly discovered evidence, (2) committed clear error or the initial decision was manifestly unjust, or (3) if there is an intervening change in controlling law." *Sch. Dist. No. 1J, Multnomah Cnty., Or. v. ACandS, Inc.*, 5 F.3d 1255, 1263 (9th Cir. 1993) (citation omitted).

#### ARGUMENT FOR RECONSIDERATION

- I. The Court erred in its interpretation of EMTALA, resulting in an injunction that is internally contradictory and an interpretation of EMTALA that is at odds with the Medicare Act.
  - A. The Court's interpretation of stabilizing treatment does not align with the statutory definition and results in a contradictory injunction.

The Court's preliminary injunction has a clear error. The preliminary injunction begins by stating it will enjoin Idaho from enforcing Idaho Code § 18-622(2)-(3) "as applied to medical care required by [EMTALA]." Mem. Decision and Order, Dkt. 95 (Order) at 38. But in the very next sentence, the Court enjoins Idaho from certain acts when an abortion "is necessary to avoid . . ." certain emergency medical conditions. *Id.* at 39. That is not the standard specified by EMTALA, even if one were to assume that EMTALA requires certain medical treatment (it does not).

Under EMTALA, if an applicable hospital determines that the person has an emergency medical condition, then it must either provide for transfer to another medical facility or provide "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." 42 U.S.C. § 1395dd(b)(1)(A) (emphasis added). This means that a hospital must, within its capabilities, 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." Id. § 1395dd(e)(3)(A) (emphasis added); see also 42 C.F.R. § 489.24(d)(1)(i). This is not a "necessary to avoid" standard, which expands EMTALA requirements to a prevention, as opposed to stabilization, standard. The injunction also broadens EMTALA's reach by applying it to "any medical provider or hospital," not just those subject to EMTALA. See 42 U.S.C. §§ 1395dd(a)-(b), dd(e)(5)

The injunction also goes beyond the scope of the challenge to Idaho Code § 18-622. It purports to enjoin Idaho from "seeking to impose any other form of liability on" hospitals or medical providers that conduct an abortion under the novel "necessary to avoid" standard. Order 39. However, the United States only sought to enjoin enforcement of Idaho Code § 18-622. Dkt.

17-1 at 20 (asking the Court to enjoin Idaho "from enforcing Idaho Code § 18-622(2)-(3) as applied to EMTALA-mandated care."). That code section specifies the forms of liability that may be imposed. Thus, the injunction extends to other, unidentified "form[s] of liability" that are not contained in the challenged Section 18-622(2)-(3). See Fed. R. Civ. P. 65(d); Skydive Ariz., Inc. v. Quattrocchi, 673 F.3d 1105, 1116 (9th Cir. 2012) ("Courts should not enjoin conduct that has not been found to violate any law."). In addition, the second sentence of the injunction does not limit itself to Idaho Code § 18-622. As currently written, the injunction appears to bar the State from enforcing its Fetal Heartbeat Act that has not been contested by the United States (as discussed during oral argument). That law remains effective where Idaho Code § 18-822 is unenforceable and contains its own sanctions for unlawful abortions. Idaho Code § 18-8805(4). Thus, the injunction's second sentence, as it is currently written, appears to impermissibly enjoin the Fetal Heartbeat Act, which is not at issue in this litigation.

B. The Court misunderstands EMTALA to force a state to allow a particular "treatment"—here the taking of an unborn child's life—which is inconsistent with EMTALA and the Medicare Act.

The Court's Order understands EMTALA to require a particular method of "care," even if the State does not permit the procedure in the circumstance identified. Order 17 ("EMTALA-mandated abortions"); 19 (EMTALA obligates "abortion care"); 20 ("EMTALA requires abortions that the affirmative defense would not cover."); 21 (EMTALA "demands abortion care to prevent injuries that are more wide-ranging than death."); 31, 32 (faulting Idaho for "curb[ing] abortion as a form of medical care," which it believes frustrates "EMTALA's purpose.") In short, the Court understands EMTALA to mandate the medical procedures offered across the nation: If

<sup>&</sup>lt;sup>1</sup> This interpretation of EMTALA flows from the interpretation advanced by the United States, which was promulgated by the July 11, 2022 CMS guidance and corresponding letter sent by HHS Secretary Becerra. To the extent this lawsuit arises from this agency action—an issue that is currently unclear—the Court's interpretation of EMTALA and the associated Order violates the major questions doctrine and the State incorporates the Legislature's argument contained at Section III(B)(1) of the Legislature's Motion for Reconsideration as to why the major questions doctrine has been violated. *See* Dkt. 97-1 at 10-11.

MEMORANDUM IN SUPPORT OF STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95) - 3

a physician believes an abortion would be a stabilizing treatment, the United States through EMTALA can force the State to allow the abortion, even if the State does not allow the abortion in that circumstance. The Court's conclusions regarding EMTALA reflects clear error.

Understanding EMTALA as mandating abortions as medical care is an afront to the State's sovereignty and police power. *Dobbs* returned regulation of abortion to the states, subjecting such regulation to rational basis review, and beginning with "a strong presumption of validity." 142 S. Ct. at 2284 (citation omitted). In preemption cases, there is an assumption that must be made that "historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (cleaned up). Here, regulation of the medical profession has long been recognized as a power of states. *E.g.*, *Hawker v. New York*, 170 U.S. 189, 192-93 (1898). Indeed, constitutionally, Congress lacks the authority to regulate the practice of medical care or to intrude upon the states' prerogatives regarding criminal law. *Cf. United States v. Morrison*, 529 U.S. 598, 613, 618 (2000); John Yoo, *Schumer and Graham are both wrong on abortion: Congress can't legislate it*, The Wash. Post (Sept. 15, 2022, 2:54 PM EDT), <a href="https://www.washingtonpost.com/opinions/2022/09/15/schumer-graham-abortion-laws-unconstitutional/">https://www.washingtonpost.com/opinions/2022/09/15/schumer-graham-abortion-laws-unconstitutional/</a>. Consistent with this constitutional limit, 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.

The Court's understanding of EMTALA is also contrary to Congress's intent in enacting the Medicare and EMTALA statutes. As noted by the Idaho Legislature, Dkt. 97-1 at 8-9, Medicare prevents the federal government from interfering in the supervision or control of the practice of medicine or the manner in which medical services are provided. 42 U.S.C. § 1395. "Courts across the country uniformly hold that this section 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*, --- F. Supp. 3d ---, ---, 2022 WL 3639525, at \*25 (N.D. Tex. 2022) (quoting *Goodman v. Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989)). EMTALA

also recognizes that the "capabilities of the staff and facilities" at the hospital limit stabilizing treatment that a hospital is obligated to provide. 42 C.F.R. § 489.24(d)(1)(i). A long-extant statute such as EMTALA cannot now be given a transformative expansion of its regulatory reach by an allegedly just-discovered unheralded power to regulate abortions at the federal level. *Cf. West Virginia v. EPA*, 142 S. Ct. 2587, 2610 (2022).

This understanding of EMTALA is confirmed by other Congressional enactments. Congress has made clear through the Weldon Amendment that the United States cannot through Medicare discriminate against hospitals or providers that do not provide abortions. *See* Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, title V, § 507(d)(1), 136 Stat. 496 (2022). Any thought that EMTALA mandates the performance of abortions through the threat of the loss of federal funds for non-performance runs afoul of the Weldon Amendment.

Finally, the anti-commandeering doctrine prohibits Congress from issuing "direct orders to the governments of the States." *Murphy v. NCAA*, 138 S. Ct. 1461, 1476 (2018). To be sure, the federal Congress can regulate private actors within its power, and when it does, preemption can occur. *Id.* at 1479-81. But Congress cannot directly compel state governments to enact and enforce a federal regulatory program, nor compel state officers (or officers of their political subdivisions) to administer or enforce a federal program. *Id.* at 1477 (citations omitted).

With these legal principles in mind, the Court's assertion that EMTALA mandates abortion is plainly incorrect. EMTALA requires hospitals to provide stabilizing treatment (or transfer), but EMTALA does not specify that an abortion must be a form of treatment available when the State has otherwise disallowed it.<sup>2</sup> Nor could it, because Congress cannot compel (or commandeer)

<sup>&</sup>lt;sup>2</sup> This point is not inconsistent with *Matter of Baby "K"*, 16 F.3d 590 (4th Cir. 1994). There, a hospital *could* provide *and had* provided a treatment—meaning the treatment was not regulated by the state. However, the state allowed physicians to *elect* not to provide treatment he or she viewed as medically or ethically inappropriate. The Fourth Circuit found that the statute *allowing the physician election not to provide treatment* directly conflicted with the EMTALA requirement to provide stabilizing treatment. The *Baby "K"* issue is thus focused not on the manner of treatment

States to allow abortions. Medicare and EMTALA respect historic state regulation of the practice of medicine through the states' police powers. What EMTALA regulates are persons (hospitals accepting Medicare and their physicians) through a requirement to provide screening and, if necessary, treatment or transfer. This has long been understood to be the objective of EMTALA: It is a "Patient Anti-Dumping Act" enacted in response to a concern that "hospitals were 'dumping' patients who were unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized." *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995). The Court erred in interpreting EMTALA to mandate that a State allow a particular "treatment."

### II. The Court erred in its interpretation of Idaho Code § 18-622.

Having first misunderstood EMTALA to require the performance of abortions, the Court then misunderstood Idaho Code § 18-622 to prevent the performance of abortions in those circumstances when it understood EMTALA to require them. The Court did this by erroneously viewing the affirmative defense in Idaho Code § 18-622(3) as unclear and ambiguous. It said the statute lacked "clarity" "because of the statute's ambiguous language and the complex realities of medical judgments." Order 27. It interpreted Section 622(3) to require "the patient's death must be imminent or certain absent an abortion." *Id.* at 21, 27. The Court saw the quandary as being "when, precisely, does the 'necessary-to-prevent-death' language apply?" *Id.* at 28. The Court then characterized the affirmative defense as being an "empty promise" only "available to physicians once they make that often 'medically impossible' determination that death [i]s the guaranteed outcome." *Id.* at 29. Multiple problems exist with the Court's interpretation. Read properly, the

<sup>(</sup>although in that as-applied case, one form of treatment was sought), but instead on whether a physician *can be allowed to choose* not to provide stabilizing treatment. This case stands opposite of the *Baby* "K" case. Idaho has disallowed abortion—removing this "treatment" option in all circumstances except where the exceptions (the affirmative defenses) identified in Section 18-622, apply. The fact that Idaho has disallowed an abortion in all other instances is something that this Court must respect under 42 U.S.C. § 1395—not a direct conflict with the stabilizing treatment requirement.

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affirmative defense in Idaho Code § 18-622 allows the performance of an abortion when the woman's treating physician determines in good faith that the abortion is necessary to prevent her death—regardless of imminence.

# A. The plain language of Idaho Code § 18-622(3) does not contain an imminency requirement.

The Court erred in reading an imminency requirement into Idaho Code § 18-622. *Id.* at 20; *see also id.* at 27. The plain language of Idaho Code § 18-622(3) does not contain an imminence or temporal requirement. *See State v. Clark*, 168 Idaho 503, 508, 484 P.3d 187, 192 (2021) (requiring a court to begin with the literal words, which are given their plain meaning). Even the United States did not add an imminence-of-death requirement. *E.g.*, Dkt. 17-1 at 8, 15. The Court was clearly incorrect to turn to statements from physicians in interpreting Idaho Code § 18-622(3). *See* Order 28 (citing Cooper Suppl. Decl., Dkt. 86-5; Corrigan Suppl. Decl., Dkt. 86-3). Furthermore, in Idaho, statutes should be construed to avoid a conflict with the state or federal constitution. *See State v. Gomez-Alas*, 167 Idaho 857, 866, 477 P.3d 911, 920 (2020). The Court turned toward, not away from, a constitutional issue.

## B. Idaho Code § 18-622's affirmative defense related to the life of the mother is clear.

The Court expressed significant concern about a perceived lack of clarity in the affirmative defenses. Order 26-31. The Court's analysis hinted at whether the statute was vague as part of its ambiguity analysis, even though this issue was not raised by the United States. The Idaho Supreme Court is currently considering whether Idaho Code § 18-622 is vague.<sup>3</sup> But similar laws restricting abortion have likewise used phrases such as "necessary to prevent the death" or "necessary to

<sup>&</sup>lt;sup>3</sup> As part of that analysis, the Idaho Supreme Court will interpret Idaho Code § 18-622. The Idaho Supreme Court is the "final arbiter[] of the meaning of state statutory directions." *Whole Women's Health v. Jackson*, 142 S. Ct. 522, 536 (2021) (plurality opinion of Gorsuch, J., in part II-C) (citation omitted). As such this Court should defer its interpretation of Idaho Code § 18-622 and adopt the Idaho Supreme Court's interpretation of Idaho Code § 18-622. Oral argument on the pending Idaho Supreme Court petitions is currently set for September 29, 2022, and an opinion will issue in due course—potentially before this motion is fully ripe for the Court's consideration.

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preserve her life," and state and federal courts have upheld their constitutionality.<sup>4</sup> Even Idaho's pre-*Roe* statutes contained such a requirement. Contrary to the Court's hinted analysis, the plain language of Idaho Code § 18-622(3) and "necessary to prevent the death of the pregnant woman" are well understood, and use language with meanings that withstood the test of time. The Court's concerns do not support the conclusion that the statute is ambiguous.

# C. Even if the Court found the language ambiguous, the Court failed to follow Idaho law on how to determine the meaning of a statute.

Given that the Court found the plain language unclear, the Court committed clear error by not engaging in the construction necessary to give effect to legislative intent. *Nelson v. Evans*, 166 Idaho 815, 820, 464 P.3d 301, 306 (2020). It took none of the steps to engage in statutory construction, such as looking at the context, public policy, and legislative history. (Nor was any of this argued or provided by the United States.) Instead, the Court relied on declarations from physicians. *See* Order 28-29. Its failure to follow what it was required to do was clear error.

# D. The Court also erred in its understanding of the purpose of the Idaho law that weighs the balance of human life.

As expressed by the Idaho Legislature, Dkt. 97-1 at 4-6, an alternative way of looking at Idaho Code § 18-622 is as an exercise of the state's police power that values the life of an unborn child, but recognizes when an unborn child's life may be taken when both it and its mother are suffering an emergency medical condition. As the *Texas v. Becerra* court pointed out, EMTALA imposes on a physician the duty to screen and to treat or transfer "equally to the pregnant woman and her unborn child." *Texas*, 2022 WL 3639525, at \*20. As such, "EMTALA's equal obligations to the pregnant woman and her unborn child create a potential conflict in duties that the statute does not resolve." *Id.* State law fills this void. *Id.* As such, it does not create a direct conflict (or make compliance with both physically impossible). *Id.* at \*21. This alternative view of the statute

<sup>&</sup>lt;sup>4</sup> E.g., Crossen v. Att'y Gen. of Ky., 344 F. Supp. 587, 590 (E.D. Ky. 1972) (three-judge court) (rejecting challenge that statute "does not describe what the probability of a woman's death must be in order to legalize the performance of an abortion" as "nothing more than a guise for the plaintiff's belief that the statute too rigidly regulates.")

MEMORANDUM IN SUPPORT OF STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95) - 8

is not an obstacle to "the full purposes and objectives of Congress": Idaho's policy weighing "however successful or unsuccessful—does not undermine the provision of care to the indigent or uninsured. It does not compel the 'rejection of patients." *Id.* at \*22 (citations omitted). In fact, it carries out Congress's purpose. *Id*.

- III. The Court erred in concluding that the United States met its heavy burden of showing that it is physically impossible to comply with both statutes and in showing that Idaho's law effectively nullified EMTALA.
  - A. The Court erred in finding that it was physically impossible to comply with both statutes.

The Court found it was physically impossible to comply with both statutes because: (1) EMTALA requires a physician to provide an abortion, regardless of what state law allows; (2) "Idaho statutory law makes that treatment a crime"; and (3) "[W]here federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws." Order 19. The Court cited no authority for this proposition. The United States cited *Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001), Dkt. 86 at 17, but that case offered no support for this proposition. The United States did not meet its heavy burden of showing it was a "physical impossibility" to comply with both statutes.

The first error in the Court's analysis is that it understands EMTALA to force a state to allow a particular "treatment," even if the State has decided not to allow the "treatment." This is incorrect, as discussed above. The second error is that it concludes it is physically impossible to comply with (1) a law that requires the provision of stabilizing treatment (within the bounds of treatment a physician and hospital can provide) and (2) a state law generally disallowing abortion, subject to two exceptions. But there is no direct conflict between the state law defining the bounds of care that can be provided and a requirement of EMTALA to provide stabilizing treatment within those bounds. Nor is it physically impossible for a physician to comply with both laws. In fact, EMTALA (and Medicare) expects that hospitals and physicians will work within the bounds of what they can do to provide treatment. The requirement in EMTALA, that stabilizing treatment be

provided "within the staff and facilities available at the hospital," embodies this point. *See also* 42 C.F.R. § 489.24(d)(1)(i) ("Within the capabilities of the staff and facilities available").

With respect to the abortions that Idaho allows through exceptions in Section 18-622, the affirmative defenses are not in direct conflict with any EMTALA requirement.<sup>5</sup> The key point is the medical professional can be "legally blameless" for providing an abortion that is within the bounds of Idaho law and that is stabilizing treatment. *See* Order 20. Idaho can choose to criminalize abortions except under three circumstances. *See Dobbs*, 142 S. Ct. at 2284. Its use of an affirmative defense ultimately allowing the medical professional to be "legally blameless," means that it is not impossible to comply with both statutes.

Though the Court faults Idaho's policy of only allowing two exceptions, comparing it to other situations where the Court understands an abortion could be stabilizing treatment, Order 20, this again misunderstands what the State can do (control types of "treatment") as compared to what EMTALA requires: treat or transfer within the bounds of the treatments the State authorizes. And although the Court ultimately asserts that EMTALA is "broader than the affirmative defense on two levels," Order 21, those two "levels" flow from the misunderstanding discussed above—the Court's misunderstanding that EMTALA can require abortions in circumstances that a State law does not allow.

Finally, the Court observes that "neither the State nor the Legislature have convinced the Court that it is possible for healthcare workers to simultaneously comply with their obligations under EMTALA and Idaho statutory law." Order 24. The clear error in this statement, which the State assumes is a summation of the Court's reasoning, is that the Court says it placed the burden on the Defendant to prove the likelihood of success element with respect to impossibility. That is contrary to well-established law requiring that the movant, by a clear showing, carry the heavy

<sup>&</sup>lt;sup>5</sup> Although the Court, Order 20, and United States, Dkt. 86 at 7, see a difference between an exception and an affirmative defense, affirmative defenses deriving from statutes are generally understood to be exceptions to statutory liability. *See, e.g., United States v. Pearson*, 274 F.3d 1225, 1232-33 (9th Cir. 2001); *United States v. Freter*, 31 F.3d 783, 788 (9th Cir. 1994).

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burden of establishing they are entitled to the preliminary injunction. *Earth Island Institute v. Carlton*, 626 F.3d 462, 469 (9th Cir. 2010).

# B. There cannot be a direct conflict because EMTALA's obligations are triggered by the voluntary choice of hospitals.

There was also error in finding that the United States met its burden to demonstrate physical impossibility for dual compliance and a direct conflict between EMTALA and Idaho Code § 18-622. There can be no impossibility sufficient to enjoin a validly enacted state statute that applies uniformly where EMTALA is not mandatory and not a law of general applicability. Hospitals and providers are not required to serve Medicare patients or to bill Medicare for their services. Those are voluntary choices. The fact that conditions to Medicare funding are codified does not change the fundamental nature that those provisions only apply when voluntarily agreed to by the participant. There is simply no impossibility to comply with two generally applicable laws. In fact, it is impossible to violate EMTALA, even in circumstances identified by the Court, unless a hospital or provider has voluntarily entered into an agreement. To hold otherwise, and find a direct conflict between EMTALA and Idaho law, is to leverage federal policy interpretations to usurp and allow private entities to contract away the sovereign's constitutional interest.

# C. Idaho's regulation of abortion does not nullify the anti-patient-dumping purpose of EMTALA.

EMTALA's express savings clause, 42 U.S.C. § 1395dd(f), begins by saving "any State or local law requirement, *except* to the extent that the requirement directly conflicts with a requirement of [EMTALA]." (emphasis added). This Court must give "great weight to Congress's inclusion" of the savings provision. *In re Volkswagen "Clean Diesel" Mktg., Sales Pracs.*, & *Prods. Liab. Litig.*, 959 F.3d 1201, 1213 (9th Cir. 2020). Under obstacle preemption, the Court would have to find that the state law essentially nullifies or defeats the federal law's purpose. *Id.* at 1214. The United States did not meet its burden.

The Ninth Circuit concluded that Congress' purpose with EMTALA was to "respond" to a concern "that hospitals were 'dumping' patients who were unable to pay, by either refusing to

provide emergency medical treatment or transferring patients before their conditions were stabilized." *Eberhardt*, 62 F.3d at 1255; *accord Hardy v. N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789 (2d Cir. 1999); *Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) (collecting cases). In contrast, this Court found that "Congress's clear purpose was to establish **a bare minimum of** emergency care that would be available to all people in Medicare-funded hospitals." Order 25 (emphasis added). But the *Arrington* case the Court cites does not use that language, and it's clear that the phrase "adequate emergency medical care" as used in the case is directed at ensuring that persons arriving at an emergency medical department are not dumped—not requiring particular care or its quality. *See Marshall*, 134 F.3d at 322 (noting that required screening "is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms"); *see also Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) ("Its core purpose is to get patients into the system who might otherwise go untreated . . ."). The Court therefore erred by recharacterizing the purpose of EMTALA.

The Court also erred in finding that Idaho's law stands as an obstacle to EMTALA's purposes. Idaho's policy choice of not allowing the taking of an unborn child's life except as identified by two affirmative defenses does not nullify Congress' purpose of ensuring that all individuals who arrive at an emergency medical department receive care, regardless of their insurance status. Furthermore, the fact that Congress chose not to impose certain sanctions as part of EMTALA, *see* Order 32, is irrelevant given that States can criminalize abortion and thus impose

<sup>&</sup>lt;sup>6</sup> The *Arrington* case cited *Vargas v. Del Puerto Hospital*, 98 F.3d 1202, 1205 (9th Cir. 1996), which in turn cited *Eberhardt*, 62 F.3d at 1255. As discussed above, *Eberhardt* understood EMTALA's purpose was to respond to patient dumping.

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consequences on those persons who take an unborn child's life outside of the exceptions Idaho recognizes.<sup>7</sup>

Nor do the United States' doctors' speculative statements establish that Idaho Code § 18-622 nullifies EMTALA's anti-patient dumping purpose. The doctors' concern about delaying care is unfounded, given their misinterpretation of Idaho Code § 18-622. *See* Order 32. Likewise, the speculative concerns about recruiting OB/GYNs, *id.* at 34, and whether this will result in "fewer providers performing health and life-saving abortions," *id.*, shows no obstacle to EMTALA, as EMTALA does not regulate hospital staffing. EMTALA specifically recognizes that stabilizing treatment must consider the capabilities of the hospital and its staff. Simply because Idaho's policy choice does not align with the federal government's or individual doctors' policy preferences, does not establish a direct conflict with EMTALA.

The Court is simply wrong to assert that EMTALA had a purpose of establishing that all individuals "have access to a minimum level of emergency care"; i.e., that EMTALA mandates abortions. *Id.* Idaho has chosen a uniform policy of disallowing abortions subject to two exceptions applicable to insured and uninsured persons alike. Idaho's policy choice does not directly conflict with EMTALA; it does not nullify EMTALA's anti-patient dumping purpose.

## IV. When the Court grants reconsideration, it should find that the United States does not have a likelihood of success on the merits.

Because the federal government cannot force the state to adopt a particular "treatment," this Court should conclude that the United States has no likelihood of success with respect to abortions that Idaho does not allow. With respect to the abortions that Idaho allows—where the

<sup>&</sup>lt;sup>7</sup> As an aside, the Court thought Congress was careful in avoiding sanctions that could result in a decrease in available emergency care. Order 34. Yet, the exact opposite is true; the very same House Judiciary Committee report, *see id.* at 26, recommended "a strong incentive" of "extend[ing] the civil fines provision to the responsible physician, so that the physician, like the hospital, could be fined." H.R. Rep. No. 99-241, pt. 3, at 6 (1985), *reprinted in* 1986 U.S.C.C.A.N. 726, 728. And indeed, physicians are subject to civil penalties of \$50,000 per violation. 42 U.S.C. § 1395dd(d)(1)(B).

physician determines in his or her good faith medical judgment that the abortion is necessary to prevent the death of the mother, and in the cases of rape or incest—the Court should conclude there is no direct conflict with EMTALA. Thus, the Court should find the United States has not carried its burden of demonstrating a likelihood of success with respect to these abortions.

# V. When the Court grants reconsideration, it should find that the other factors support denying the preliminary injunction.

Additionally, when the Court grants reconsideration, the Court should find that there is no irreparable harm to the United States, given that the State has acted within its bounds. *See also* Dkt. 66 at 17-18. The Court should, instead, find that Idaho will suffer irreparable harm if an injunction is issued because the injunction would invade Idaho's sovereign interest in regulating abortion. Likewise, the Court should find that the public interest favors Idaho continuing to regulate within the realm stated by the United States Supreme Court. As noted, Idaho will be harmed by disallowing the effectuation of its policy, even in this limited area. *See id.* at 18-20 (citing *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers)).

### VI. The district court erred in concluding that the United States had a cause of action.

In response to the State's contention that the United States did not have a cause of action on which to proceed under the Supremacy Clause, the Court concluded that the suit was appropriate because the United States was bringing this action in equity. Order 13. However, the Court erred in failing to address whether Congress' chosen remedial scheme foreclosed such an action. *See* Order 13-14; Dkt. 66 at 7; *see also* Dkt. 80 at 8-9. Any suit in equity is barred here because Congress provided an extensive remedial scheme in which the United States could redress any violation of EMTALA, whether through EMTALA's penalties or through the Medicare Act provider agreement enforcement provisions. 42 U.S.C. § 1395dd(d), 42 U.S.C. § 1395cc(b)(2). The State, like the Legislature, recognizes that *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320 (2015) bars this Court from hearing the claim brought by the United States. *See* Dkt. 97-1 at 11-12.

## VII. The district court erred in concluding that the United States had standing.

The Order also erred in finding the United States had standing when the United States lacks the legal authorization to do so and failed to demonstrate an actual injury-in-fact. A federal court has an "independent obligation" to thoroughly examine a plaintiff's standing. FW/PBS, Inc. v. City of Dallas, 493 U.S. 215, 231 (1990) (citation omitted). This is particularly critical where, as here, standing is "substantially more difficult to establish" because the United States is not the object of the hypothetical government action. Lujan v. Defenders of Wildlife, 504 US 555, 562 (1992) (citation omitted). The importance is heightened when the matter pertains to maintaining the foundations and separations of our dual form of government. United States v. Mattson, 600 F.2d 1295, 1297 (9th Cir. 1979). However, the Order only gave cursory review to this foundational issue. And a closer examination of the three harms found in the Order show the United States lacks this threshold requirement. The United States conceded it does not assert third-party standing. Dkt. 86 at 3. Thus, it must assert an actual injury traceable to Idaho Code § 18-622.

The Order cited two cases concerning statutes very different from EMTALA to conclude the United States' sovereign interests were harmed. The first case, *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765 (2000), involved the False Claims Act, and addressed a relator's standing. Although not at issue in *Vermont*, the False Claims Act has an express statutory authorization for the United States to bring suit. 31 U.S.C. § 3730. EMTALA does not have that, and so it was error to rely on that case's legally distinct injury.

The second concerned the Immigration and Nationality Act, which preempted the field, and which concerned the United States' significant authority over immigration policy. *Arizona v. United States*, 567 US 387, 394-95, 401, 406, 416 (2012). The Supreme Court did not address standing as part of its analysis. Another vital distinguishing factor is that the INA contains express provisions for the United States to direct and closely supervise the state actors assisting in the enforcement of federal immigration law. *United States v. Arizona*, 641 F. 3d 339, 348-349, 351 (9th Cir. 2011), *rev'd in part on other grounds*, 567 U.S. 387 (2012). None of these elements are present within EMTALA. The Medicare Act expressly disclaimed regulating the practice of MEMORANDUM IN SUPPORT OF STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95) - 15

medicine and EMTALA disclaimed preempting state regulation except when there is direct conflict. The State does not have a role in assisting in the enforcement of EMTALA; therefore, the United States does not direct or closely supervise the State's activities in this area. And, EMTALA is solely based on Congress's spending authority rather than any constitutional or inherent power. Thus, it is clear error to rely on *United States v. Arizona* to establish an injury to the United States sufficient to create standing in this matter.

It was also clear error to rely on *In re Debs*, 158 U.S. 564 (1895) to find standing in this case based on the "general welfare." Order 15. *Debs* contains the nebulous statement that an "injury to the general welfare, is *often* of itself sufficient to give [every government] a standing in court" even when the government does not have a direct pecuniary harm. 158 U.S. at 584 (emphasis added). Taking this statement in isolation, it appears to give standing in any action to a governmental entity acting in the "general welfare." But even setting aside the problem that this would virtually eliminate boundaries on governmental standing, what is the "general welfare"? This dispute exemplifies this dilemma where Idaho disagrees that the United States' policy preferences with regard to whether and to what extent abortion advances the "general welfare." *Dobbs* established that, in the abortion arena, States are responsible for acting for the general welfare.

Moreover, other courts grappling with this vague statement in *Debs* have not interpreted it in the same generalized manner as it was used in the Order. *See Mattson*, 600 F.2d at 1298-1299 (discussing cases). Specifically, the Ninth Circuit in *Mattson* considered whether the United States had standing to sue based upon several federal acts and programs. *Id.* at 1299, 1299 n.4. It also analyzed a line of cases including *Debs* and found that the United States lacked standing to assert claims where there was no property interest, interference with national security, or burden on interstate commerce. *Id.* at 1298-99. Hence, it found the United States lacked standing to redress a violation of a federal law requiring care and treatment for individuals with developmental disabilities because the United States' interest "ha[d] not extended beyond providing funds for the

various programs and acting in a supervisory role." *Id.* at 1299. Thus, Ninth Circuit precedent prohibits finding that the United States has standing here, where its interest is limited to providing and supervising Medicare funds.

Finally, the third harm used to justify standing is the United States' claimed benefit of its bargain in providing Medicare funds in exchange for emergency medical care treatment, or here, abortion. Order 15. However, EMTALA was enacted after *Roe*. Thus, it is a fallacy that the United States bargained for abortion when abortion was a constitutional right. The United States could not bargain for something that could not be withheld, even if private entities could bargain away the State's Tenth Amendment right.

Ultimately, EMTALA bargained for emergency medical care for patients who were unable to pay for emergency medical care. Although the United States is concerned that a provider will not provide an abortion when, in its opinion, it is the most desirable form of treatment, the record does not suggest that physicians would cease treatment or only observe a patient. Thus, there is no concrete, actual or imminent harm to the United States that a hospital will violate EMTALA by failing to provide treatment, or that such violation cannot be redressed through the authorized remedies.

VIII. The district court erred in concluding that the United States' understanding of EMTALA did not invade the State's Tenth Amendment reserved powers and that the interpretation of EMTALA amounted to coercive spending.

As noted by the Idaho Legislature, too, Dkt. 97-1 at 13-15, the Order erred in disregarding whether United States' interpretation of EMTALA and position in this litigation amounted to unconstitutionally coercing the State into surrendering its sovereign authority to regulate abortion. The Order erred in its conclusion that, because EMTALA was enacted 35 years ago, there could be no issue. Yet, EMTALA was enacted in the *Roe* era, and it is just now that the United States has asserted in this litigation that EMTALA requires, regardless of state law, that Idaho offer abortions.

As the U.S. Supreme Court described, Congress impermissibly puts a gun to the head of states when it threatens a substantial amount of the state's funds unless the state agrees to what the United States wants, calling this "economic dragooning." *NFIB v. Sebelius*, 567 U.S. 519, 581-82 (2012). The Spending Clause and the Tenth Amendment do not allow that action. *Id.* at 582. The *NFIB* Court primarily focused on two elements of the Medicaid expansion at issue. First, if a state did not comply with the new requirements that arose after acceptance and implementation of the Medicaid program, it risked the existing Medicaid funding upon which it relied. *Id.* at 580, 584. The second element was the significance of the financial inducement that was at stake. *Id.* at 582-84. In short, the two principals of an impermissible coercive scheme are (1) imposing new conditions for old money and (2) the significance of the threatened funds.

Here, the power to regulate abortion was returned to the states just months ago. However, it is Medicare funding for Idaho's hospitals that are put at risk unless the State chooses to surrender some of its sovereign power over abortion. The United States' position, fresh within the last two months, is that there is a new requirement under EMTALA: that states authorize abortions any time stabilizing treatment is needed. In other words, when Idaho hospitals accepted the EMTALA conditions, there was no legal tension between what the State could prohibit and what EMTALA required. Now, it is a new condition that the federal government seeks to require—that providers in Idaho be allowed to terminate the lives of unborn children in more circumstances than what the State would otherwise allow. Hence, the federal government has imposed a new post-acceptance condition on the existing Medicare funding for Idaho hospitals that provide emergency care.

Beyond the approximately \$1 billion per year in Medicare funding at risk to Idaho's hospitals, *see* Dkt.  $17-10 \, \P$  6, any hospitals that are excluded from Medicare would not be able to bill for Medicare patients—putting a substantial number of Idahoans at risk of losing access to (or even be able to afford) medical care. Thus, the consequence to Idaho is to either surrender its policy choice regulating abortion, or hospitals and citizenry to lose Medicare benefits on which they rely. These potentially devasting consequences leave Idaho without a legitimate choice.

This is not a situation where Congress uses its taxing and spending authority to merely encourage or incentivize state regulatory and policy choices. *See New York v. United States*, 505 U.S. 144, 166 (1992). Rather, the federal government is using a pre-*Dobbs* legislative scheme to abolish the State's policy choices post-*Dobbs* in the emergency medical care setting. Its position is that hospitals that accept millions in Medicare funds are exempt from State law. The coercive nature of this is unmistakable, not just to the providers and hospitals, but to the State, which is coerced with threats directly to its budget or indirectly to the ability of its citizens to obtain healthcare.

## IX. The Court erred in concluding that this is an as-applied challenge.

The Court said the United States "has mounted a textbook, as-applied challenge." Order 17. Yet, the United States sought to have the Court issue injunctive relief regarding all instances where there is EMTALA treatment, not a particular circumstance involving one mother and one set of facts, and that would allow such relief to follow through to non-party hospitals, physicians, and pregnant women in Idaho. What the Court has before it is a facial challenge that must be decided on the facial standard.

Imagine a plaintiff concerned about a referendum petition and the state's public records act (PRA). Imagine the complaint asserts the PRA violates the first amendment as applied to referendum petitions—obviously the PRA's application to other documents is unchallenged. According to this Court's analysis, this is a "textbook, as-applied challenge." But the Court would be wrong. *John Doe No. 1 v. Reed*, 561 U.S. 186 (2010), explains that this type of challenge is indeed a facial challenge, despite having characteristics of an as-applied challenge.

#### CONCLUSION

The Court should grant the motion for reconsideration, vacate the preliminary injunction, and on reconsideration deny the United States' motion for a preliminary injunction.

DATED this 21st day of September, 2022.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

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#### CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of September, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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MEMORANDUM IN SUPPORT OF STATE OF IDAHO'S MOTION TO RECONSIDER PRELIMINARY INJUNCTION (Dkt. 95) - 21

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#### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

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

v.

THE STATE OF IDAHO,

Defendant.

NOTICE OF FACTUAL CLARIFICATION

The United States respectfully submits this Notice of Factual Clarification, and the accompanying Second Supplemental Declaration of Dr. Lee A. Fleisher, M.D., to avoid any ambiguity

in the factual record presently before this Court. The United States also submits, however, that this factual clarification is not material to the issues before the Court.

Earlier in this case, Dr. Fleisher submitted a declaration that, among other things, reported the number of claims that were made to Medicaid and the Children's Health Insurance Program (CHIP) for ectopic pregnancies within the State of Idaho for the years 2018 through 2021. *See* Dkt. No. 17-3, ¶ 36. Those numbers were 98 for 2018; 72 for 2019; 103 for 2020; and 108 for 2021. *Id.* 

As explained in more detail in Dr. Fleisher's accompanying declaration, upon further examination of this data, HHS determined that those numbers were accurate with respect to claims submitted, but did not reflect the actual number of individual ectopic pregnancies, because sometimes a single ectopic pregnancy can involve multiple claims from different providers involved in rendering care (e.g., one claim from the hospital, and a separate claim from the physician performing the procedure). HHS has now de-duplicated the numbers, to identify the actual number of ectopic pregnancies in each year (as opposed to the number of claims associated with those ectopic pregnancies). Based on the de-duplicated data, HHS reports that the number of discrete ectopic pregnancies reflected in Medicaid/CHIP claims data are as follows: 66 in 2018; 48 in 2019; 76 in 2020; and 73 in 2021. See 2d Suppl. Fleisher Decl. ¶¶ 2-4.

The United States does not believe that this minor change in numbers is material to any of the past proceedings in this case, or to any of the issues currently before the Court. The United States wishes to ensure that the factual record in this case is as precise as possible, however, and therefore submits this Notice and accompanying declaration for purposes of avoiding any potential ambiguity associated with the previously submitted information.

Dated: September 15, 2022

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Respectfully submitted,

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#### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

V.

THE STATE OF IDAHO,

Defendant.

#### SECOND SUPPLEMENTAL DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties. The following statements are provided as a supplement to the prior written testimony that I submitted in relation to this case on August 8, 2022.

- 1. In my first declaration submitted in this case, in paragraph 36, I reported the number of claims that were made to Medicaid and the Children's Health Insurance Program ("CHIP") for ectopic pregnancies within the State of Idaho for the years 2018 through 2021. As stated in that paragraph, those numbers were 98 for 2018; 72 for 2019; 103 for 2020; and 108 for 2021.
- 2. Those numbers are accurate with respect to the overall number of *claims* submitted to Medicaid/CHIP for ectopic pregnancies. In the course of further analyzing this data after my initial declaration was submitted, however, HHS determined that the initial data did not fully de-duplicate beneficiaries who had multiple claims related to a

single pregnancy. In some cases, particularly for services delivered in a hospital setting, a single episode of care can generate multiple claims from different providers involved in rendering care (for instance, one claim from the hospital, and a wholly separate medical claim from the physician performing a procedure).

- 3. HHS thereafter sought to fully de-duplicate the claims data, such that each Medicaid/CHIP beneficiary is counted only once per year regardless of how many claims for a pregnancy termination are found for the beneficiary. This de-duplicated data would more accurately reflect the discrete number of ectopic pregnancies within the State of Idaho for Medicaid/CHIP beneficiaries, as opposed to the overall number of claims submitted in connection with ectopic pregnancies.
- 4. I am informed that HHS has determined, based on the fully de-duplicated data, that the number of discrete ectopic pregnancies reflected in Medicaid/CHIP claims data are as follows: 66 in 2018; 48 in 2019; 76 in 2020; and 73 in 2021.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 15 day of September, 2022 in Philadelphia, PA.

Lee A. Fleisher, M.D.

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#### UNITED STATES DISTRICT COURT

#### DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Case No. 1:22-cv-329

Plaintiff,

STATE OF IDAHO'S NOTICE OF SUPPLEMENTAL AUTHORITY

v.

THE STATE OF IDAHO,

Defendant.

The State of Idaho brings to this Court's attention the preliminary injunction issued Tuesday by the U.S. District Court for the Northern District of Texas in *State of Texas v. Becerra*, No. 5:22-cv-00185-H (N.D. Tex. Aug. 23, 2022) ("Memorandum Opinion and Order"). A copy of that decision is attached as Exhibit A to this filing.

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Because the State of Idaho only learned of this decision this morning through news sources, it has not yet had a full opportunity to consider how the *Texas* court's decision should be persuasive in aspects of this current lawsuit, or in the pending preliminary injunction motion.

DATED this 24th day of August, 2022.

OFFICE OF THE ATTORNEY GENERAL

By: <u>/s/ Brian V. Church</u>
BRIAN V. CHURCH

Deputy Attorney General

#### **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 24th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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/s/ Brian V. Church
BRIAN V. CHURCH
Deputy Attorney General

## EXHIBIT H

#### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

Defendant.

#### SUPPLEMENTAL DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties. The following statements are provided as a supplement to the prior written testimony that I submitted in relation to this case on August 8, 2022.

- 1. I have reviewed the Declarations of Dr. Richard Scott French (the "French Declaration"), ECF 75-1, and Dr. Kraig White (the "White Declaration"), ECF 66-1. Both the French Declaration and the White Declaration discuss my prior declaration, including my testimony explaining that the appropriate stabilizing treatment for some emergency medical conditions experienced by pregnant patients is termination of pregnancy. French Decl. ¶¶ 17-29; White Decl. ¶¶ 2-7.
- 2. Both Dr. French and Dr. White agree with my prior statements that termination of pregnancy is the necessary and appropriate medical treatment for pregnant patients under the circumstances discussed. As Dr. French explains: "[E]very one of the

five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that a life-saving surgery would more likely than not result in the termination of the pregnancy." French Decl. ¶ 29. Dr. White similarly agrees. White Decl. ¶¶ 2-7.

- 3. The only point of disagreement with my prior testimony appears to be Dr. French's interpretation of the Idaho statute that is challenged in this case. Dr. French states that "life-saving surgery is not an abortion, and the language in the Idaho statute permits such life-saving surgeries/procedures." French Decl. ¶ 29. Dr. French's interpretation is inconsistent with my reading of the Idaho statute, which defines abortion to mean "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." Idaho Code § 18-604(1). While I agree that the statutory definition of "abortion" in the Idaho Code covers some procedures that would not be characterized as an abortion *in the medical community*, the language of the Idaho statute appears to cover any medical treatment that requires intentional termination of a pregnancy regardless of the circumstances.
- 4. Additionally, it appears that Dr. French and Dr. White believe that the Idaho statute does not threaten criminal liability when termination of the pregnancy occurs in response to a "life-threatening" condition. French Decl. ¶¶ 29-30; White Decl.¶ 2. From a medical perspective, I do not believe "life-threatening," which generally implies only a *risk* of death, necessarily has the same meaning as the Idaho law's affirmative defense—

"necessary to prevent . . . death"—which generally implies avoiding a certainty (or at least very high probability) of death.

- 5. Regardless, I do not believe "life-threatening" fully encompasses all potential emergency medical conditions for which a pregnant patient might be entitled to stabilizing treatment under EMTALA. Specifically, the State's declarations do not address situations in which termination of pregnancy is necessary to protect a patient's health, or to ensure that a pregnant patient will not suffer a serious impairment to their bodily functions or serious dysfunction of any bodily organ or part, but where the patient's life is likely not in danger at that point in time. As explained in my prior declaration, many pregnancy conditions pose serious risks to the patient's health that are appropriately stabilized through termination of pregnancy, even though a physician may not be able to establish or know that termination of pregnancy is "necessary to prevent the death of the woman" at that time. In those instances, termination of pregnancy would be necessary to protect the patient's health, even though death is not immediately threatened.
- 6. For example, I previously discussed the scenario of a patient who comes to an emergency department with preterm premature rupture of membranes ("PPROM"), which is a premature breaking open of the amniotic sac that increases the risk of severe intra-amniotic infection. If PPROM is diagnosed, the patient faces serious risk of infection which could impair the function of any number of organs or bodily functions. As an example, developing significant infection in the uterus could seriously impair the patient's reproductive organs if the condition is allowed to deteriorate. Providing stabilizing treatment in the form of termination of pregnancy at the point of diagnosis would be an appropriate means to preserve the patient's reproductive organs at that time. If stabilizing

treatment were withheld at that point in time, the infection could only worsen and treatment at a later point would present significantly higher risk of complications, potentially requiring a hysterectomy and/or harming their future fertility. If a patient is diagnosed with PPROM before severe infection occurs, a patient may not immediately face a life-threatening risk. However, immediate treatment through termination of pregnancy may be necessary because delaying treatment would allow the condition to progress, thereby threatening other bodily organs and functions, including but not limited to future fertility. Under those circumstances, the patient and physician may decide that termination of pregnancy may be the appropriate stabilizing treatment to protect the patient from organ dysfunction or other bodily impairment, even though the stabilizing treatment is not yet in response to a life-threatening circumstance.

7. In general, medical risk to individual patients exists along a continuum, and there are no medical "bright lines" specifying when exactly a condition becomes "life-threatening" or "necessary to prevent the death" of the pregnant patient. Even in situations where it is unclear whether the patient's life is in immediate danger, it may be apparent that the patient's condition will continue to deteriorate absent stabilizing treatment through termination of pregnancy. Under those circumstances, terminating the pregnancy to avoid the patient's health falling into serious jeopardy, bodily functions being seriously impaired, or organs becoming seriously dysfunctional (rather than waiting to see if and/or when the patient's condition worsens to the point that they are about to die) may be the appropriate recommendation from the physician as medically necessary and is what EMTALA requires.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 18th day of August, 2022 in Philadelphia, PA.

Lee A. Fleisher, M.D.

Jul. 700

# EXHIBIT I

#### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

Defendant.

REPLY DECLARATION OF DR. EMILY CORRIGAN

## REPLY DECLARATION OF DR. EMILY CORRIGAN IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Emily Corrigan, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at Saint Alphonsus Regional Medical Center in Boise, Idaho and I previously submitted a declaration in this case. I have now reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. As with my first declaration, unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

#### The State's Physician Declarations Do Not Reflect Relevant Personal Experience or Risk.

2. To begin, my overall reaction having reviewed the declarations of Drs. White, Reynolds and French is that none of them face the same risk of criminal prosecution for violating

Idaho Code § 18-622 as myself, Dr. Seyb, Dr. Cooper, and most other Idaho physicians and nurses who must comply with EMTALA while treating critically-ill pregnant patients.

- 3. Although Dr. Reynolds says she was raised in Idaho, after she completed her residency in Nevada she chose to continue practicing medicine there where I understand abortion to be legal. See Dr. Reynolds Decl. ¶ 2. She does not indicate in her declaration any intention to return to Idaho to help either patients in Idaho or her physician colleagues deal with these new laws, which have no effect on her living and practicing in Nevada. If anything, her declaration is evidence of Idaho's dire OB/GYN shortage as compared to more urban areas like Las Vegas where she trained, has practiced ever since, and is part of a very large group of physicians. The OB/GYN residency program in Nevada will continue to produce six new OB/GYN physicians per year to supply their workforce. Idaho hospitals will have to convince OB/GYN physicians from out of state to move here and practice under the stressful circumstances created by Idaho Code § 18-622 and our already understaffed OB/GYN Departments.
- 4. Dr. French does not state in his declaration where he currently is practicing medicine but he speaks of his time in Idaho in the past tense only. *See* Dr. French Decl. ¶¶ 5, 6. His online Doximity profile indicates that he is currently practicing in Hawaii. Abortion healthcare is not currently under legal threat in Hawaii.
- 5. Dr. White says that he is practicing in Moscow, Idaho, a town that is only 8 miles from Pullman, Washington. Pullman Regional Hospital features a level IV trauma center, so any high-risk patient that Dr. White encounters could quickly and easily be transferred to a hospital in a state where abortion is legal.
- 6. Additionally, Dr. White says that he is working as a Family Medicine Physician in the Emergency Department at a small hospital. In my experience, if a pregnant patient is having

a significant complication, the Emergency Department provider requests a consultation from an OB/GYN who then assumes management of the patient.<sup>1</sup> Reading his declaration, I noted that while Dr. White says that in the last 6 years he has treated "life-threatening situations that have included obstetrical emergencies," he does not say whether he has ever personally made the decision to terminate a patient's pregnancy to stabilize her condition. Also, complex obstetric patients are usually transferred from a critical access hospital to a tertiary care center before a decision is made regarding an emergency abortion. As such, there is nothing in his declaration to suggest that Dr. White has ever faced the situations that Drs. Seyb, Cooper, and I have faced many times in our careers, that we described in our declarations, and that is at the crux of the conflict between federal and state law if Idaho Code § 18-622.

#### The State's Physician Declarations Are Wrong About "Necessary to Prevent Death"

- 7. Each of the State's physician declarations suggests that termination of the pregnancy was necessary to save the pregnant patient's life in each of the cases I discussed. Having not treated those patients or studied their files, those physicians do not speak from experience and are simply wrong. There are several reasons why.
- 8. First, it is medically impossible to say that death was the guaranteed outcome for Jane Doe 1, 2, and 3 if we had not terminated their pregnancies when we did. None of their conditions *necessarily* would have ended in death. Jane Doe 1 could have developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but could still be alive. Jane Doe 2 possibly would have developed kidney failure requiring lifelong dialysis or hypoxic

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<sup>&</sup>lt;sup>1</sup> Patients with emergency pregnancy-related conditions are frequently triaged and treated in a hospital's labor & delivery department, which is considered part of the "emergency department" for purposes of EMTALA.

brain injury but escaped death. Jane Doe 3 was at risk for stroke and severe lung injury but may have survived her illness. Each of these women potentially would have had to live the remainder of their lives with significant disabilities and chronic medical conditions as a result of their pregnancy complication. If I was asked if the abortion was necessary to prevent the death of the patient in each of those cases, I could not necessarily say yes with absolute certainty. I do not believe that any physician could. That said, in each case, abortion was necessary to stabilize the patient's health.

- 9. While the State's physician declarations speak in terms of absolutes, medicine does not work that way in most cases. Death may be a possible or even probable outcome, but different outcomes may also be possible or probable. This is why doctors frequently refuse to answer the question, "What are my chances?" I frequently tell my patients that I do not possess a "crystal ball" that informs me of exactly what the future holds for them, I can only make an educated guess based on my training and experience. We can provide empirical data on how many patients survived a particular condition, if that data was collected and verified (usually through peer review). But we can only rarely predict with certainty a particular outcome. This is why we follow the standard of care—something that *is* knowable and is consistent with our obligations under EMTALA. And this is also why the Idaho law will have a chilling effect on physicians in treating pregnant patients facing health emergencies.
- of the Idaho law is the correct one, ignoring that the law does not define when a procedure would be deemed "necessary to prevent the death of the pregnant woman." For those of us faced with the obligation to comply with that law and left only with an affirmative defense, we must ask: Is any risk of death sufficient? Must the risk be greater than 50%? 75%? Or must the physician

wait until the patient's heart has stopped beating to provide the termination and begin resuscitative efforts? Idaho Code § 18-622 does not say. What we can say is that a physician's good-faith belief that it was necessary is *not* enough, as it appears the law does not have any sort of good-faith exception. Just because one physician says he or she believes termination is "necessary" to prevent the pregnant patient's death does not mean all physicians would agree, and certainly does not guarantee all prosecutors, judges, and jurors untrained in medicine would agree. Instead, a physician must rely on hope that a judge or jury would interpret what is "necessary" in the same way as the physician.

- 11. Third, even if death is eventually the necessary outcome absent termination of a pregnancy, the Idaho law tells physicians to wait until death is near-certain and in the meantime the patient will experience pain and complications that may have lifelong disabling consequences. Even if a patient is ultimately provided the medically necessary care, Idaho Code § 18-622 will delay that care until a debate determines whether it is truly "necessary to prevent the death of the pregnant woman." In my view, the State's physician declarations unrealistically downplay the reason physicians will wait until they are sure an abortion is necessary to prevent death. A physician administering an emergency abortion in Idaho would be risking their professional license, livelihood, personal security, and freedom. Our malpractice insurance may not cover us for performing an act that some may view as a crime. Of course, we may hesitate to provide the same care after the Idaho law is effective—the law is designed for that very purpose.
- 12. Fourth, the State's physician declarations ignore that it is not only physicians who perform abortions who may be exposed to serious risk. Idaho law also exposes nurses and others who assist doctors to criminal and license-suspension risk. As a result, there will be some cases where even if a physician may be comfortable proceeding, she may have no nurse or other staff to

assist because of the fear that this law has instilled in healthcare workers in Idaho. That too will undermine patient care, causing harm to patients and increasing the risk associated with the abortion being performed.

13. Just because out-of-state doctors do not fear prosecution under Idaho Code § 18-622 does not mean that those of us who actually do practice in Idaho feel the same way. I have said to the administration at my hospital that the OB/GYN Physicians in Idaho are "bracing for the impact" of this law, as if it is a large meteor headed towards Idaho. The OB/GYN and Maternal Fetal Medicine physicians who work at tertiary care hospitals in Boise feel this trepidation most acutely because we receive the most complex cases from other hospitals in the state that have fewer resources. Dr. Cooper, Dr. Seyb, and I are all part of this group of physicians that is most at risk from the implications of this law. There are no declarations submitted in support of this law from any physician with this level of current and intimate knowledge of the risks and challenges we are facing. If this law goes into effect, there will be serious negative consequences for patients and healthcare workers alike. While the pregnant people of Idaho will likely suffer serious physical and emotional trauma or even death as a result of this law, the OB/GYN physicians who practice here will face the untenable situation of making decisions for the care of critically ill patients while facing an impossible choice between complying with either state or federal law but not both.

#### The Prosecutor's Declaration Provides Little to No Comfort.

14. I reviewed the declaration from Prosecuting Attorney Grant Loebs. A declaration from one prosecutor in Twin Falls County does not provide me with any comfort that I would not be criminally prosecuting for terminating a patient's pregnancy where required by EMTALA but not 100% necessary to prevent imminent death to the patient. Idaho has lots of prosecutors. They may have different views of how to exercise their discretion. Some may even think that they have

an obligation to enforce the law in Idaho and may disagree that it was passed only to send a message. And other prosecutors who haven't even been elected yet may have still other views of the law. The consequences of a criminal prosecution are so serious, even if I could present a defense, that Idaho Code § 18-622 is necessarily going to change how emergency medical care is administered in Idaho, even if one prosecutor promises he doesn't plan to enforce it.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

 $\frac{8/18/22}{\text{Date}}$ 

Emily Corrigan, M.I

# EXHIBIT J

#### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

Defendant.

DECLARATION OF DR. AMELIA HUNTSBERGER

### DECLARATION OF DR. AMELIA HUNTSBERGER IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

- I, Amelia Huntsberger, being first duly sworn under oath, state and depose upon personal knowledge as follows:
- 1. I am a board-certified Obstetrician-Gynecologist (Ob/Gyn) physician at Bonner General Health, a critical access hospital in Sandpoint, Idaho. Bonner General Health is a small, rural hospital that provides Labor and Delivery services. The nearest Neonatal Intensive Care Unit (NICU) is 45 miles from Sandpoint.
- 2. In 2008, I graduated from the University of Washington School of Medicine which is the regional medical school for Washington, Idaho, Wyoming, Montana and Alaska. I completed my residency in Obstetrics and Gynecology at the University of Michigan in Ann Arbor in 2012. I am board certified in General Obstetrics and Gynecology since 2015.
- 3. I was invited to join the Idaho Perinatal Project advisory board in 2018. Improving pregnancy outcomes by reducing maternal and infant morbidity

and mortality is the mission of the Idaho Perinatal Project. I am a member of the Idaho Maternal Mortality Review Committee. I am currently the Idaho Section Chair of the American College of Obstetricians & Gynecologists.

- 4. I moved to Sandpoint, Idaho in 2012 and began working as an Ob/Gyn at Bonner General Health.
- 5. I grew up in a rural area and feel patients in rural areas deserve high quality, compassionate health care just like patients in more populated areas.

  Serving a rural community has been my goal since I was a medical student.
- 6. I have reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. The facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

## Abortion Is Sometimes Medically Necessary Even When It Is *Not* Necessary to Prevent the Mother's Death.

- 7. The physician declarations from Drs. White, Reynolds, and French seem to suggest that whenever abortion is medically necessary, it is necessary to prevent the mother's death. That is simply not the case.
- 8. At Bonner General Health, we do not perform purely "elective abortion." However, I have personally treated patients whose health condition requires abortion as stabilizing care—even if those patients were not necessarily facing death in the absence of an abortion.

- 9. A relatively common example of this is ectopic pregnancy. Not every patient with an ectopic pregnancy will die without an abortion. But terminating an ectopic pregnancy is the standard of care to prevent serious risks to the mother, including internal bleeding, injury to the fallopian tube or other organs in the abdominal cavity, impaired fertility, and in some cases, death.
- 10. I have reviewed the declaration of Dr. Reynolds stating that termination of ectopic pregnancy is not an abortion. While Dr. Reynolds may not consider the termination of ectopic pregnancy to be abortion, she does not acknowledge how Idaho law defines abortion. Unlike Dr. Reynolds, who practices in Las Vegas, Nevada, I practice medicine in Idaho. I have reviewed Idaho law and it defines abortion as "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." An ectopic pregnancy is a "clinically diagnosable pregnancy" even if the fetus is not viable, and Idaho law has no exceptions for lethal anomalies. There are various means to terminate an ectopic pregnancy, all of which are intended to cause the death of the fetus and all of which are performed with knowledge that they will cause the death of the fetus.
- 11. For example, I treated a patient in her mid-30s who presented to the hospital with spotting and pelvic pain. An ultrasound showed an ectopic pregnancy

with a fetal heartbeat. Free fluid, presumed to be blood, was seen on the pelvic ultrasound. I counseled the patient about the risks, benefits, and alternatives available to her and she elected and consented to undergo laparoscopy with removal of the ectopic pregnancy. At the time of surgery, there was 750 mL of blood in her abdomen despite normal blood pressure and pulse. A patient with stable vital signs like this one is experiencing a health emergency—her health is in "serious jeopardy" within the meaning of EMTALA. However, a patient with stable vital signs may not appear to be near death. If I had let her condition deteriorate before performing a life-saving abortion, however, she would have faced increased pain, risk of further hemorrhage inside the abdomen, anemia, possible development of disseminated intravascular coagulopathy (DIC), need for blood transfusion and other blood products. She also could have died had we waited too long and been unable to manage the complications that may have arisen. Ectopic pregnancy is a potentially life-threatening diagnosis. The timeline for it to develop into an acutely lifethreatening condition is difficult to precisely predict, even for a medical expert. Stabilizing treatment with abortion as defined by Idaho law was necessary to prevent a life-threatening situation from evolving.

## Waiting Until Abortion Is Necessary to Prevent the Patient's Death Will Cause Serious Harm.

12. With ectopic pregnancies and pregnancy of unknown location, waiting until an abortion is necessary to prevent death is harmful and dangerous. In some ectopic pregnancies and pregnancies of unknown location, treatment with methotrexate may be offered. Methotrexate is a chemotherapy drug used to kill

rapidly dividing cells (which therefore targets pregnancy). Methotrexate can be used 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" (the Idaho definition of abortion). If we must wait until a patient's death is imminent to terminate her ectopic pregnancy or pregnancy of unknown location, we can no longer use methotrexate and must provide surgical intervention. Surgical intervention carries its own risks, including potential loss of a fallopian tube, damage to nearby abdominal structures (like bladder, bowel, uterus, ovary, ureter and/or blood vessels), infection, bleeding and potential loss of the patient's ability to become pregnant naturally in the future.

- 13. I have personally treated patients who sadly experienced this outcome. One patient had the devastating experience of having both tubes removed for separate instances of ruptured ectopic pregnancy. As a result, she has no option for spontaneous pregnancy and would require in vitro fertilization (IVF) or adoption to grow her family. Appropriate use of methotrexate when the patient first presents with ectopic pregnancy, if successful (which it typically is), may avoid the need for surgical intervention and increase likelihood of successful future pregnancy. The total abortion ban will cause doctors to hesitate before using methotrexate, putting their patients' health and fertility at risk.
- 14. Another example shows the consequences of delaying an abortion.

  This patient was a female in her 40s with 3 living children who presented to the hospital via ambulance with heavy vaginal bleeding. She reported that she was

approximately 14 weeks gestation. She had been experiencing very heavy bleeding at home. She initially declined care including bloodwork, pelvic ultrasound and/or Ob/Gyn consultation in the ER. She was not unstable at this time, and I could not say an abortion was necessary at that time to prevent her death. However, she continued bleeding profusely in the ER until she was unable to stand due to hemorrhage causing symptomatic anemia. After a syncopal episode, she agreed to be seen by an Ob/Gyn and I was emergently called. She was pale and unable to sit up in bed due to her anemia at the time of my evaluation. She was bleeding heavily from the vagina making visualization during pelvic exam very difficult. I removed products of pregnancy from the open cervix in the ER, however, very brisk bleeding continued and she was counseled to undergo emergent D&C in the Operating Room (OR) for a second trimester incomplete abortion. I reviewed the risks, benefits and alternatives of D&C (dilation and curettage- a procedure to remove the products of pregnancy from the uterus) in addition to the risks, benefits and alternatives of blood transfusion and she consented to both. I took her to the OR for D&C. She was hypotensive and tachycardic; she was unstable at that time. She received 2 liters of IV fluids, transfusion of 3 units of packed red blood cells in the OR, another unit of packed red blood cells in the Recovery Room immediately following her surgical procedure. She received 2 units of fresh frozen plasma given her large volume blood loss. I had to order platelets from Spokane, Washington, which did not arrive until several hours later via taxi and were transfused into the patient. She stayed in the

hospital for 2 days. She received another transfusion of 2 units of blood for ongoing symptomatic anemia prior to her discharge home.

15. I provide these details regarding this patient's case because her case shows what can happen when we delay an abortion that would otherwise be the recommended medical intervention. In this case, the patient chose to delay the abortion but if Idaho Section 622 takes effect, physicians in Idaho will be forced to wait until the abortion is necessary to prevent death of the patient. Patients may experience serious complications, have negative impact on future fertility, require additional hospital resources including blood products, and some patients may die.

## <u>The Idaho Law Will Have Serious Negative Effects on Medical Care in Idaho.</u>

- 16. While Drs. White, Reynolds and French suggest that the law is clear to them, it certainly is not clear to me. The goal in medicine is to effectively identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. One impact on medical care may be a reluctance to use effective, evidence-based treatments like methotrexate for ectopic pregnancy or pregnancy of unknown location.
- 17. Most rural hospitals in Idaho, like my own institution, were not offering "elective terminations" of pregnancies prior to the *Dobbs* decision. Yet those of us who treat pregnant patients are deeply worried about what these abortion laws will mean for the practice of routine reproductive care given the Legislature's broad definition of "abortion."

18. In rural areas, patients may live 30-60 miles or more away from medical care. There is less access to specialty care, less blood stocked in the blood bank, less access to other blood products. At the critical access hospital where I work, we don't have platelets in the blood bank as previously described. If necessary, platelets come via taxi from a neighboring state and may take hours to arrive. Most rural hospitals do not have interventional radiology (can provide additional treatment option for maternal hemorrhage), Maternal Fetal Medicine expert (high risk pregnancy doctor), nor a dedicated Critical Care doctor that manages the Intensive Care Unit (ICU). Rural hospitals, like my own, may not have dialysis capabilities. As per EMTALA, some patients will need to be transferred to a hospital that can offer a higher level of care. If there is bad weather, it is not possible to use a helicopter and then a patient will travel by ambulance 45 to 60 miles away depending on which hospital accepts the patient and/or which hospital has the resources that the patient needs. We work with the resources that we have to the best of our ability, but we don't have the same staff, equipment and resources as larger and/or urban centers. For rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA.

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- 19. I hope that the Court takes into consideration how physicians actually practicing in Idaho and treating Idahoans perceive the law and its effect of criminalizing evidence-based medical care. A doctor practicing in Las Vegas or Honolulu does not have the same experience and does not face the same potentially life-altering dilemma that we will face if this law is allowed to take effect.
- 20. I have also reviewed the declaration of the attorney, Mr. Loebs, and it does not make me feel any better about how the law will negatively affect patients and physicians in Idaho. How can I trust that every prosecutor in the State has exactly the same beliefs, much less every *future* prosecutor? If the law allows prosecution, it is not reassuring that I can simply rely on the good faith of prosecutors. A prosecutor may believe that they have an obligation to enforce the law as it is written. I have a career and a family of my own so I cannot just hope that all prosecutors will exercise discretion in exactly the same way as Mr. Loebs.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 18th day of August 2022, in Sandpoint, Idaho.

8/18/2022

Date

Amelia Huntsberger, M.D.

# EXHIBIT K

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

 $\mathbf{v}.$ 

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-329

SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D.

# SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

- 1. I have read the briefs submitted by the State of Idaho and the Idaho Legislature and the supporting Declarations. I submit this supplemental declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.
- 2. As stated in my Declaration (Dkt.17-7), pregnancy is not always straight forward and complication free. If I terminate a "clinically diagnoseable pregnancy" the affirmative defense available to me under Idaho Code §18-622 requires me to prove that in my medical judgment and based on the facts known to me, the termination was necessary to prevent the death of the pregnant woman. The vast majority of patients do not present at death's door. For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated

treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense.

- 3. My patient Jane Doe 1 is just one of countless patients whom I have treated with a diagnosis of preeclampsia with severe features. Medical standard of care dictates that expectant management, or continued observation without treatment of a pregnancy with a diagnosis of preeclampsia with severe features is contraindicated in the setting of a fetus not expected to survive including those at a pre-viable gestational age. The reason for this is because preeclampsia with severe features places a patient at risk for both acute and long-term complications and the clinical course involves progressive deterioration of the maternal and fetal condition. Patients with preeclampsia with severe features may present with varying symptoms. For some it is severe hypertension, for others it is evidence of kidney or liver damage on laboratory assessment. Others present with severe intractable headache pulmonary edema and some at the extreme end of the spectrum with HELLP syndrome (hemolysis, elevated liver enzymes, low platelets). The definitive medical treatment for pre-viable preeclampsia with severe features is termination of pregnancy. The medical rationale to treat preeclampsia with severe features once it has been diagnosed is not always to prevent death; in the majority of cases it is to avoid further deterioration, physical harm, and threat to future fertility and long-term health.
- 4. Maternal death remains relatively uncommon which is due to contemporary and evidence based medical practices and protocols which we use to treat the patient in an appropriate and timely manner rather than waiting until they experience the anticipated and severe complications of their illness.
- 5. Preterm pre-labor rupture of membranes (PPROM) is a circumstance in which the amniotic sac has ruptured too early. I have treated countless patients with PPROM and for some

patients this occurs in the pre-viable or peri-viable time frame. This condition carries a multitude of risks including intra-amniotic infection, endometritis, placental abruption, and retained placenta. It can also lead to maternal sepsis, acute kidney injury, hemorrhage, need for blood transfusion, and hysterectomy. Maternal deaths due to infection do occur. The clinical presentation of PPROM can vary. In addition to abnormal leakage of amniotic fluid, some may also experience bleeding from an abruption or labor. For others, they may present with signs and symptoms of intraamniotic infection. In the pre-viable and peri-viable setting the chance of pregnancy loss is very high. The clinical course for patients with PPROM can be unpredictable. They may be stable at one moment and bleeding profusely or demonstrating systemic signs of infection the next. Having PPROM places them at risk for hemorrhage which can be further compounded by an intraamniotic infection or sepsis. Hemorrhage, if significant and unresponsive to first line therapies can necessitate a hysterectomy which would eliminate future fertility. The treatment for intraamniotic infection or hemorrhage related to PPROM is to remove the products of conception from the uterus. It is my opinion these are the types of scenarios where the condition may not meet the "necessary to prevent the death of the pregnant woman" requirement for the affirmative defense under I.C. §18-622 but I would be required under EMTALA to stabilize a condition that without immediate medical attention would place the patient's health in jeopardy.

6. I have read the declarations of Dr. White and Dr. Reynolds. As a maternal-fetal medicine physician I provide direct care for high-risk pregnant patients and also serve as a subspecialist consultant for other medical providers. In my role as a subspecialist physician I am consulted regularly and from around the state of Idaho by a variety of physicians including generalist OB/Gyn, family practice, and emergency medicine for assistance in managing pregnant patients and pregnancy complications. As a subspecialist physician at a tertiary care center who

receives pregnancy related patient transports regularly from around the state, I frequently see conditions that threaten the health of the patient. The three examples in my initial declaration were all cared for within the past year. Even if it is just one patient's health being severely impacted or life lost related to the inability of her medical providers to care for her, that is unacceptable.

- Dr. Reynolds states that "any effort to redefine abortion to include treatment of 7. ectopic pregnancies is medically baseless and, in my judgment, inexcusable." Idaho Code §18-622 defines an abortion as the termination of a "clinically diagnosable pregnancy". Medically speaking, the healthcare community would not classify treatment of an ectopic pregnancy as an abortion. This statute was not written using medically accepted definitions or terminology. Therefore, providers are left with the plain language of the law and because an ectopic pregnancy is a clinically diagnosable pregnancy this leads to provider fear of prosecution for providing the evidence-based and medically indicated treatment for those patients. Dr. Reynolds, who practices in Nevada, states that Idaho physicians, "may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors" and "[t]he doctor-declarants' comments about 'fears' and 'chillings' of doctors already in Idaho and of Ob-Gyn doctors considering relocating to Idaho do not ring true to me." As a physician who is practicing in Idaho and through my personal interactions with health care providers around the state as well as through my positions with ACOG, the Idaho Perinatal Project advisory board, and the Idaho Coalition for Safe Reproductive Healthcare, provider fear and unease is real and widespread.
- 8. I have read the declaration of Dr. French who states "the 'life-saving' abortion that results in the death and dismemberment of a fetus in the uterus can cause an entire cascade of reactions that would in fact worsen many of the scenarios that are presented as life-saving." Surgical abortion is a safe treatment. The risk of death associated with childbirth is 14 times higher

than that with abortion. For those complications related directly to the pregnancy itself such as HELLP syndrome, preeclampsia with severe features, severe hemorrhage, and intraamniotic infection, this safe surgical procedure is the definitive treatment that will stop the progression and reduce risks of bodily harm.

9. I have read the declaration of Mr. Loebs. A single prosecutor, from a different jurisdiction from where I practice medicine stating that he would not prosecute a physician based on a few patient examples does not alleviate my fear of criminal prosecution. Similarly, his speculation that all prosecuting attorneys in Idaho would interpret these scenarios the same way he does gives me no security. Implicit in prosecutorial discretion, is the fact that each prosecutor will decide for themselves whether to prosecute these cases, leaving medical providers unable to predict or know how each prosecuting attorney will proceed.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 19<sup>th</sup> day of August 2022, in Boise, Idaho.

8/19/22 Date Mylie Cooper MD

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#### UNITED STATES DISTRICT COURT

## **DISTRICT OF IDAHO**

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-329

STATE OF IDAHO'S RESPONSE TO THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION (Dkt. 17)

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#### INTRODUCTION

The United States seeks here to undermine Idaho's policy choice of how to regulate abortion, as allowed by *Dobbs*, by wielding its substantial financial clout under the Medicare program to invalidate that choice. Rather than awaiting an actual instance of supposed conflict, it asks this Court for broad injunctive relief that far exceeds what settled legal principles countenance. The United States asks this Court to only partially read the Emergency Medical Treatment and Labor Act's preemption provision that says that "[t]he provisions of [EMTALA] do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). The United States' own declarations fail to demonstrate a direct conflict between EMTALA and Idaho Code § 18-622.

In sum, the United States seeks a far-reaching preliminary injunction—one manifestly inconsistent with the preemption provision in EMTALA—preventing the State, its officers, employees, and agents, from enforcing Idaho's abortion regulation when stabilizing treatment is required by EMTALA. But the United States has not met its burden for issuance of a preliminary injunction. It fails to satisfy the requirements of a facial challenge because it cannot demonstrate that all applications of Section 18-622 are inconsistent with EMTALA requirements. The other factors do not favor granting a preliminary injunction. The United States' motion for a preliminary injunction should be denied.

#### BACKGROUND

The federal government allows hospitals to participate as providers in its Medicare program. 42 U.S.C. §§ 1395-1395lll. "Medicare is a federally funded health insurance program for aged and disabled persons." *Palomar Med. Ctr. v. Sebelius*, 693 F.3d 1151, 1154-55 (9th Cir. 2012). A hospital, as a provider of services under Medicare, is subject to various requirements as

part of its relationship with the federal government, which are expressed in a provider agreement. 42 U.S.C. § 1395cc. A particular set of requirements applies to a hospital with an emergency department, which are expressed in the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. By regulation, the Centers for Medicare and Medicaid Services (CMS) has more specifically identified what the provider agreement requires of hospitals with respect to EMTALA. 42 C.F.R. § 489.24. In this litigation, the United States contends that there is a conflict between the requirements of EMTALA and the soon-to-be-effective Idaho Code § 18-622.

# I. The Emergency Medical Treatment and Labor Act (EMTALA)

Congress enacted EMTALA in 1986 to address the then-growing concern about "patient dumping"—the transfer or discharge of expensive-to-treat uninsured patients for whom "hospitals have an economic incentive to dump." Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1187-88 (1986) (citation omitted). EMTALA was passed to require hospital emergency departments to provide "adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995) (citing H.R. Rep. No. 241, 99th Cong., 1st Sess. (1986)); *see also Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039, 290 U.S. App. D.C. 31, 33 (D.C. Cir. 1991).

For hospitals with an emergency department,<sup>1</sup> if a person "comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition," EMTALA requires that the hospital provide an "appropriate medical screening

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<sup>&</sup>lt;sup>1</sup> Federal regulations identify this as a hospital that is licensed to have an emergency department, or holds itself out as providing, or actually provides (for at least one-third of all outpatient visits) "care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment," 42 C.F.R. § 489.24(b).

examination within the capability of the hospital's emergency department" to determine whether an emergency medical condition exists. 42 U.S.C. § 1395dd(a).<sup>2</sup>

If a hospital determines that the individual has an emergency medical condition, the hospital must offer to provide stabilizing treatment or transfer. *Id.* § 1395dd(b)(1). If the hospital offers stabilizing treatment, it must, "within the staff and facilities available at the hospital," provide "for such further medical examination and such treatment as may be required to stabilize the medical condition." *Id.* § 1395dd(b)(1)(A). If the hospital offers to transfer the individual to another medical facility, it must do so in accordance with 42 U.S.C. § 1395dd(c). *Id.* § 1395dd(b)(1)(B).

With respect to stabilizing treatment, to "stabilize" means "with respect to an emergency medical condition, 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 [for a pregnant woman who is having contractions] to deliver (including the placenta)." *Id.* § 1395dd(e)(3)(A).

<sup>&</sup>lt;sup>2</sup> An emergency medical condition is defined by the statute, 42 U.S.C. § 1395dd(e)(1) to mean:

<sup>(</sup>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—

<sup>(</sup>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,

<sup>(</sup>ii) serious impairment to bodily functions, or

<sup>(</sup>iii) serious dysfunction of any bodily organ or part; or

<sup>(</sup>B) with respect to a pregnant woman who is having contractions—

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

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

A hospital's obligation to a patient in the emergency department with an emergency medical condition under EMTALA is not indefinite or unlimited. Rather, the requirement to provide stabilizing treatment *ends* when either: (1) the patient is stabilized within the limits of the capabilities of the staff and facilities of the hospital; or (2) the hospital transfers the person to another hospital in accordance with EMTALA's requirements. 42 C.F.R. § 489.24(a)(ii). Further, "EMTALA's stabilization requirement ends when an individual is admitted for inpatient care." *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1168 (9th Cir. 2002). Hence, a hospital or physician has satisfied its EMTALA obligation when a patient is admitted by the hospital in good faith to provide further treatment even where the patient has not yet been stabilized. 42 C.F.R. § 489.24(d)(2)(i). Moreover, EMTALA does not apply to an inpatient "who was admitted for elective (nonemergency) diagnosis or treatment." *Id.* § 489.24(d)(2)(ii).

EMTALA also contains a preemption provision to prevent overriding state laws that may regulate the same arena but do not directly conflict with EMTALA. That provision provides: "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." 42 U.S.C. § 1395dd(f).

# II. Idaho Code § 18-622

In 2020, the Idaho Legislature enacted the Trigger Law. S.B. 1385, 65th Leg., 2d Reg. Sess. (Idaho 2020). This legislation was codified at Idaho Code § 18-622. The U.S. Supreme Court's July 26, 2022 judgment in *Dobbs* means Idaho Code § 18-622 will be effective 30 days from July 26, 2022.

Under Idaho Code § 18-622, performing or attempting to perform an abortion carries criminal and administrative penalties. Idaho Code § 18-622(2). "Abortion" is defined as "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 . . . ." Idaho Code § 18-604(1).

Idaho Code § 18-622 provides two affirmative defenses to criminal prosecution and disciplinary actions by licensing authorities. The first applies when a physician determines, "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" and "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." Idaho Code § 18-622(3)(a). The second applies when, prior to the abortion, "the act of rape or incest [has been reported] to a law enforcement agency" and "a copy of such report" has been provided to the physician who will perform the abortion. *Id.* § 18-622(3)(b). Section 18-622 is not violated if medical treatment provided to a pregnant woman by a health care professional "results in the accidental death of, or unintentional injury to, the unborn child." *Id.* § 18-622(4).

## III. Post-Dobbs Developments

On the day the Supreme Court released the *Dobbs* decision, the President remarked that his administration would take immediate action to counteract *Dobbs*.<sup>3</sup> A subsequent executive order required the Department of Health and Human Services (HHS) to consider updates to guidance regarding emergency conditions and stabilizing care.<sup>4</sup> HHS through CMS released

<sup>&</sup>lt;sup>3</sup> Remarks by President Biden on the Supreme Court Decision to Overturn Roe v. Wade, THE WHITE HOUSE (June 24, 2022), <a href="https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturn-roe-v-wade/">https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturn-roe-v-wade/</a>.

<sup>&</sup>lt;sup>4</sup> Protecting Access to Reproductive Healthcare Services, Exec. Order No. 14076, 87 Fed. Reg. 42053-54 (July 8, 2022), <a href="https://www.federalregister.gov/documents/2022/07/13/2022-15138/protecting-access-to-reproductive-healthcare-services">https://www.federalregister.gov/documents/2022/07/13/2022-15138/protecting-access-to-reproductive-healthcare-services</a>.

guidance suggesting that state laws prohibiting abortion but not including an exception for the life and health of the pregnant person were preempted.<sup>5</sup> Approximately three weeks later, the United States filed this suit.<sup>6</sup>

#### LEGAL STANDARDS

Injunctive relief is "an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008) (citing *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997)). A plaintiff seeking a preliminary injunction must establish: (1) a likelihood of success on the merits; (2) likely irreparable harm in the absence of a preliminary injunction; (3) that the balance of equities weighs in favor of an injunction; and (4) that an injunction is in the public interest. *See id.* at 20. Because the government is a party, the last two factors are analyzed together. *See Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

Under a preemption claim, a party pursuing a facial challenge "must show that 'no set of circumstances exists under which the Act would be valid." *Puente Arizona v. Arpaio*, 821 F.3d 1098, 1104 (9th Cir. 2016) (citing *United States v. Salerno*, 481 U.S. 739, 746(1987)). Such a showing is a "high bar" that the plaintiff must overcome. *Id*.

<sup>&</sup>lt;sup>5</sup> Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss, CENTERS FOR MEDICARE & MEDICAID SERVICES (July 11, 2022), <a href="https://www.cms.gov/files/document/qso-22-22-Hospitals.pdf">https://www.cms.gov/files/document/qso-22-22-Hospitals.pdf</a> (last visited Aug. 16 2022); see also Letter to Health Care Providers, SECRETARY OF HEALTH AND HUMAN SERVICES, <a href="https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf">https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf</a> (last visited Aug. 16, 2022).

<sup>&</sup>lt;sup>6</sup> FACT SHEET: President Biden Issues Executive Order at the First meeting of the Task Force on Reproductive Healthcare Access, THE WHITE HOUSE (Aug. 3, 2022), <a href="https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/03/fact-sheet-president-biden-issues-executive-order-at-the-first-meeting-of-the-task-force-on-reproductive-healthcare-access-2/">https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/03/fact-sheet-president-biden-issues-executive-order-at-the-first-meeting-of-the-task-force-on-reproductive-healthcare-access-2/">https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/03/fact-sheet-president-biden-issues-executive-order-at-the-first-meeting-of-the-task-force-on-reproductive-healthcare-access-2/</a>.

#### **ARGUMENT**

This memorandum primarily focuses on whether the United States has established a likelihood of success with respect to a facial challenge to Idaho Code § 18-622 and whether the remaining *Winter* factors warrant a preliminary injunction. Plainly, it does not.

But Idaho is constrained to note that the complaint raises other questions of significant import that eventually may require resolution. First, does the Supremacy Clause create a right of action in the United States? Judicial attention to this issue subsequent to *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320 (2015), is sparse and conclusory. *See United States v. Texas*, 557 F. Supp. 3d 810, 820 (W.D. Tex. 2021). Here, EMTALA creates a detailed remedial scheme for its enforcement by the federal government, 42 U.S.C. § 1395dd(d), and implication of a separate Supremacy Clause right of action is unnecessary. *Cf. Alexander v. Sandoval*, 532 U.S. 275, 289-90 (2001) (noting statutory enforcement provisions countered against implied right of action).

Next, if no such right of action exists, does the United States have Article III or prudential standing? The complaint alleges the injury that Section 18-622 purportedly will visit upon physicians and their patients when they are under the provisions of EMTALA, Compl. (Dkt. 1) ¶¶ 44-46, but fails to explain how it has third-party standing to redress that hypothetical injury. As the U.S. Supreme Court explained in *Kowalski v. Tesmer*, 543 U.S. 125 (2004), "[w]e have adhered to the rule that a party 'generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties" with the narrow exception in circumstances where "the party asserting the right has a 'close' relationship with the person who possesses the right" and where "there is a 'hindrance' to the possessor's ability to protect his own interests." *Id.* at 129-30 (citation omitted). Physicians, of course, can represent their own interests if prosecuted under Section 18-622 or through a pre-enforcement challenge if they face an

imminent threat of prosecution or professional discipline. *See, e.g., Summers v. Earth Island Inst.*, 555 U.S. 488, 493 (2009). A patient injured by a hospital's violation of EMTALA has a damages remedy under the statute, 42 U.S.C. § 1395dd(d)(2), and/or a malpractice suit under state law. *Bryant*, 289 F.3d at 1166. Given these remedies, the United States lacks third-party standing.

Last, the complaint alleges that the United States "has an interest in protecting the integrity of the funding it provides under Medicare and ensuring that hospitals who are receiving Medicare funding will not refuse to provide stabilizing treatment to patients experiencing medical emergencies." Dkt. 1 ¶ 49. No doubt this is at least partially true. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 676 (2012) (Ginsburg, J., dissenting in part). But, here, the complaint does not allege that Idaho operates a hospital emergency department to which EMTALA applies. In fact, Idaho's sole State-operated hospital participating in Medicare lacks an emergency department. Randy Rodriquez Decl. Under these circumstances, it defies common sense to argue that Idaho has violated some contract-like commitment by adopting Section 18-622. The requisite injury-in-fact for Article III standing on a Medicare-contract theory is absent.

For present purposes, however, it is enough to defeat the United States' motion to apply straightforward, settled facial challenge principles. To the extent that the United States argues that compliance with both EMTALA's stabilization requirement and Section 18-622 is impossible, its own expert declarations tell a different story. Many EMTALA abortions are necessary to save the mother's life. The "impossibility" prong of conflict preemption is thus not satisfied. To the extent that the United States argues that mere possibility of prosecution under Section 18-622 will chill the willingness of physicians to provide abortions "to stabilize" a patient, it ignores the heavy burden placed on it to show a "direct[] conflict[]" with an EMTALA "requirement" (42 U.S.C.

§ 1395dd(f)) that warrants preemption of an otherwise valid state law—and especially one that implicates Idaho's core police power to regulate both abortion and the practice of medicine.

# I. The United States Has Not Established a Likelihood of Success in Its Facial Challenge to the Application of Idaho Code § 18-622 to EMTALA-Covered Abortions

# A. The United States' Facial Preemption Challenge to Idaho Code § 18-622 Fails

The United States contends that Idaho Code § 18-622 "conflicts with EMTALA by subjecting physicians to criminal prosecution for terminating any pregnancy, irrespective of the medical circumstances." Mem. In Supp. Of Mot. For a Prelim. Inj. (Dkt. 17-1), at 8. Unraveled, this conflict preemption claim has two independent prongs: the statute, in material part, (1) makes the performance of an abortion (as defined in Idaho Code § 18-604(1)) unlawful and (2) imposes criminal liability on the performing physician unless (s)he "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." The first alleged defect arises because EMTALA "does not exempt any particular treatment (abortion or otherwise) from the ambit of stabilizing treatment" and "any contrary interpretation—i.e., that a hospital need not perform an abortion even when medically necessary to stabilize an emergency medical condition—would undermine EMTALA's overall purpose of ensuring 'that patients . . . receive adequate medical emergency care." Dkt. 17-1, at 11. The second alleged defect arises because "[r]elegating any exception from criminal liability to an affirmative defense ... poses an obstacle to EMTALA's 'overarching purpose of ensuring that patients . . . receive adequate emergency medical care," and "will render physicians less inclined or entirely unwilling to risk providing treatment." Dkt. 17-1, at 16.<sup>7</sup>

<sup>&</sup>lt;sup>7</sup> The United States additionally asserts that "the Idaho law conflicts with EMTALA by threatening the licenses of medical professionals who perform or assist in providing an abortion." Dkt. 17-1, at 16. This assertion similarly posits Section 18-622 "deters medical professionals from

The United States thus mounts a facial challenge to Section 18-622 with respect to any abortion performed to stabilize a medical emergency subject to EMTALA—even those when the abortion is necessary to save the mother's life. *See* Dkt. 17-1, at 20 (proposing an order "that the State of Idaho—including all of its officers, employees, and agents—[should be preliminarily enjoined] from enforcing Idaho Code § 18-622(2)-(3) as applied to EMTALA-mandated care. As the Supreme Court stated in *John Doe No. 1 v. Reed*, 561 U.S. 186, 194 (2010), "[t]he important point [for facial challenge status] is that plaintiffs' claim and the relief that would follow ... reach beyond the particular circumstances of these plaintiffs" or, in this case, the particular circumstances of an abortion. And so even though the United States' brief at times uses "asapplied," Dkt. 17-1, at 2, 7, 20, it is apparent it alleges a conflict in all instances in which both EMTALA and Section 18-622 apply, and thus brings a facial challenge.

"[A] plaintiff can only succeed in a facial challenge by 'establish[ing] that no set of circumstances exists under which the Act would be valid,' i.e., that the law is unconstitutional in all of its applications." Wash. State Grange v. Wash. State Republican Party, 552 U.S. 442, 449 (2008) (quoting United States v. Salerno, 481 U.S. 739, 745 (1987)); see also Puente Arizona v. Arpaio, 821 F.3d 1098, 1104 (9th Cir. 2016) (Although "Salerno's applicability in preemption cases is not entirely clear[,] ... [w]ithout more direction, we have chosen to continue applying Salerno."). This daunting standard reflects the fact that "[f]acial challenges are disfavored" because, inter alia, "they raise the risk of 'premature interpretation of statutes on the basis of factually barebones records[]" and "threaten to short circuit the democratic process by preventing

participating in medically necessary abortions, contrary to EMTALA's 'overarching purpose of ensuring that patients . . . receive adequate emergency medical care[.]" *Id.* at 17.

<sup>&</sup>lt;sup>8</sup> Section 18-622(3) establishes an affirmative defense for pregnancies resulting from rape or incest. The United States does not address that subsection discretely in its preemption argument.

laws embodying the will of the people from being implemented in a manner consistent with the Constitution." *Wash. State Grange*, 552 U.S. at 450-51; *see Gonzales v. Carhart*, 550 U.S. 124, 168 (2007) ("We note that the statute here applies to all instances in which the doctor proposes to use the prohibited procedure, not merely those in which the woman suffers from medical complications. It is neither our obligation nor within our traditional institutional role to resolve questions of constitutionality with respect to each potential situation that might develop.").

# 1. <u>Section 18-622 and the Stabilization Requirement</u>

The United States' declarants give both hypothetical and anecdotal examples of when the performance of an abortion to effect EMTALA-required stabilization was or would be medically appropriate. For example, Dr. Lee Fleisher provides generalized examples of illness that could jeopardize a pregnant woman's life or her health. Fleisher Decl. (Dkt. 17-3) ¶¶ 13 (ectopic pregnancy), 15 (pulmonary hypertension or embolism/severe heart failure), 17 (pre-eclampsia), 19 (uterine infection), 21 (placental abruption)). But the illnesses he references are those where a doctor could exercise good faith medical judgment to determine that the patient's life was in danger. See White Decl. ¶¶ 2-7 (explaining that ectopic pregnancy, ¶ 3; heart failure, ¶ 4; severe preeclampsia, ¶ 5; life-threatening infection, ¶ 6; and placental abruption accompanied by uncontrolled bleeding, ¶ 7; are all conditions, under the asserted facts, in which Dr. White could make a good faith medical judgment that an abortion was necessary to prevent the death of the pregnant woman). Further, despite Dr. Fleisher's decades of experience as a physician, he does not provide any specific examples of instances where a patient was suffering a non-life-threatening emergency medical condition under EMTALA that required an abortion. Significantly, Dr. Fleisher's discussions of the medical conditions that he identified often reference that a physician would have taken other measures first to control the patient's symptoms, such as antibiotics or blood pressure support, and that it is after these measures have been unsuccessful that the abortion became necessary to prevent the reasonably probable outcome of death. Dkt. 17-3 ¶¶ 15, 17, 19. Hence, the United States fails to establish that even when a pregnant patient presents with one of these conditions that an abortion is always necessary; it will depend on the patient's condition and circumstances and responses to treatment.

The supporting declarations from the Idaho physicians also conclude that in the circumstances presented an abortion was necessary because of the high risk of death or to preserve or protect her life. Corrigan Decl. (Dkt. 17-6) ¶¶ 15, 22, 23, 28; Cooper Decl. (Dkt. 17-7) ¶¶ 7, 9, 11; Seyb Decl. (Dkt. 17-8) ¶¶ 8, 10, 12. Dr. Corrigan's declaration provides examples of three "Jane Doe" patients who required emergency abortions. Dkt. 17-6 ¶¶ 9-30. Jane Doe 1 suffered a "risk of life-threatening . . . infection," id. ¶ 11, and the termination of Jane Doe 1's pregnancy was "necessary" to "preserve her life." Id. ¶ 15. For Jane Doe 2, "the risk of her death . . . was imminent[.]" Id. ¶ 23. Jane Doe 3 suffered a "dangerous pregnancy complication that can result in serious and potentially fatal complications" carrying "a high risk of maternal and fetal death." *Id.* ¶¶ 27-28. As Dr. Corrigan explained, all of these examples are dire cases where the abortion was necessary to preserve the life of the pregnant woman. These cases simply do not fall within a zone of conflict between Section 18-622 and EMTALA. So, too, Drs. Cooper's and Seyb's declarations contain anecdotal "Jane Doe" examples, and each patient suffered from life-threatening conditions, with an abortion necessary to preserve her life. Dkt. 17-7 ¶¶ 6-11; Dkt. 17-8 ¶¶ 7-13. Dr. Seyb asserts in his declaration that he and his colleagues encounter such "pregnancy-related emergencies approximately a dozen times per year." Dkt. 17-8 ¶ 6. But if the examples cited in the United States' declarations are representative samples, those cases—dire as they may be—are simply not cases where Section 18-622 conflicts with EMTALA. In short, the United States merely

identifies circumstances when stabilizing treatment necessitated by EMTALA includes an abortion. However, it fails to articulate or establish an example where the Idaho statute makes that abortion unlawful. Rather, the medical doctors have given their medical opinions that each abortion described was necessary to prevent death based on an evaluation of the circumstances and the unsuccessful measures that were attempted. The United States itself thus negates the supposed conflict between EMTALA and Section 18-622 in myriad real-life medical emergencies.

Notably, these scenarios, and the medical opinions rendered about them, are inherently fact-based (as is expressly recognized in Section 18-622), which disagreements about appropriate medical care inherently are. Therefore, it is unsurprising that litigation over the application of the EMTALA stabilization mandate has arisen only in as-applied contexts, with a focus on whether a hospital or physician provided "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. § 1995dd(e)(3)(A). The Sixth Circuit accordingly has held that "the word 'stabilized' is defined, but the definition is not given a fixed or intrinsic meaning. Its meaning is purely contextual or situational. The definition depends on the risks associated with the transfer and requires the transferring physician, faced with an emergency, to make a fast on-the-spot risk analysis." Cherukuri v. Shalala, 175 F.3d 446, 449–50 (6th Cir. 1999). In sum, a claim that Section 18-622 conflicts with the stabilization mandate is only appropriate for an as-applied, not a facial, challenge, if one were even to arise. See Matter of Baby "K," 16 F.3d 590, 597 (4th Cir. 1994) (State statute exempting a physician from providing care deemed medically or ethically inappropriate did "not allow the physicians treating Baby K to refuse to provide her with respiratory support.")

#### 2. Criminal Liability and Good-Faith Medical Judgment Affirmative Defense

The United States' facial challenge to the criminal liability provisions in Section 18-622(2) and (3) similarly fails but for different reasons. Unlike many federal statutes, EMTALA not only specifically addresses the issue of preemption but also saves from preemption "any State or local law requirement, except to the extent that the requirement *directly conflicts* with a requirement of this section." 42 U.S.C. § 1395dd(f) (emphasis added). The Ninth Circuit has issued binding instructions on how to construe this savings provision.

"When Congress has considered the issue of preemption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a reliable indicium of congressional intent with respect to state authority, there is no need to infer congressional intent to preempt state laws from the substantive provisions of the legislation." *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (per curiam). This Court therefore must "look only to this language and construe its preemptive effect as narrowly as possible." *Id.* (citing *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 517 (1992)). As for Section 1395dd(f), "[t]he key phrase is 'directly conflicts.' A state statute directly conflicts with federal law in either of two cases: first, if 'compliance with both federal and state regulations is a physical impossibility ... or second, if the state law is 'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Id.* (citations omitted).

Here, the United States argues that the mere *possibility* of prosecution for an abortion performed for stabilization purposes, together with "the affirmative defense structure *itself*," Dkt. 17-1, at 15, gives rises to an impermissible obstacle because such possibility will chill the willingness of physicians (or assisting medical professionals) to provided EMTALA-covered services. This argument should be rejected for at least three reasons.

First, the EMTALA savings provision demands a "direct[] conflict[]" with an EMTALA "requirement." As demonstrated above, and confirmed in the declaration of Dr. White, there is no direct conflict in factual scenarios presented by the United States. A physician can satisfy EMTALA's requirement to provide the necessary stabilization and avoid liability under Section 18-622 because the abortion was also necessary to prevent death. Furthermore, the United States identifies no other "requirement." Rather, the United States characterizes it as a conflict with "EMTALA's 'overarching purpose of ensuring that patients ... receive adequate emergency medical care[.]" But as the Ninth Circuit has recognized in another context, "[w]e may not interpret a saving clause as preserving a state law that would so conflict and interfere with a federal enactment that it would defeat the federal law's purpose or essentially nullify it." In re Volkswagen "Clean Diesel" Mktg., Sales Pracs., & Prod. Liab. Litig., 959 F.3d 1201, 1214 (9th Cir. 2020), cert. denied, 142 S. Ct. 521 (2021). The United States' abortion-centric argument mischaracterizes EMTALA's specific objective of preventing hospitals from dumping medically unstable patients (through discharge or transfer to another medical facility) because they were unable to pay. Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1255 (9th Cir. 1995). The range of emergency room services subject to EMTALA is immense, and as shown above, may even include abortions. To suggest that Section 18-622 would "essentially nullify" the federal law is thus no more than rhetorical flourish.

Second, it is settled that "[i]n all pre-emption cases, and particularly in those in which Congress has 'legislated ... in a field which the States have traditionally occupied,' ... we 'start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." Wyeth v. Levine, 555 U.S. 555, 565 (2009) (cleaned up). Regulation of the medical profession has long been recognized

as a quintessential state area of concern. *E.g.*, *Hawker v. New York*, 170 U.S. 189, 192-93 (1898) ("No precise limits have been placed upon the police power of a state, and yet it is clear that legislation which simply defines the qualifications of one who attempts to practice medicine is a proper exercise of that power."). As was abortion prior to *Roe v. Wade*, 410 U.S. 113 (1973). *See Dobbs*, 142 S. Ct. 2228, 2256 (2022) (noting that prior to *Roe* every single state had a law criminalizing abortion). Consequently, construing "any State . . . requirement" in Section 1395dd(f) to exclude generally applicable abortion statutes ignores this established tradition of deference to the state police power. The remedy for any alleged inconsistency between such a statute and EMTALA's stabilization mandate is an as-applied, not a facial, challenge by a physician.

Third, the United States' "chilling" preemption argument ignores the fact that EMTALA does not foreclose state law-based personal injury suits against physicians for allegedly negligent emergency room care. See, e.g., Harry v. Marchant, 291 F.3d 767, 773 (11th Cir. 2002) ("EMTALA was not intended to establish guidelines for patient care, to replace available state remedies, or to provide a federal remedy for medical negligence."). It is hardly reasonable to argue that such civil remedies may not have a deterrent impact on the willingness of physicians to perform emergency room procedures—which often demand "a fast on-the-spot risk analysis." Cherukuri, 175 F.3d at 450. The United States' chilling argument, in short, proves too much.

<sup>.</sup> 

<sup>&</sup>lt;sup>9</sup> The facial conflict-preemption claim predicated on possible loss of licensure by any health care professional "who assists in performing or attempting to perform [a criminal] abortion," Idaho Code § 18-622(2), fails for those reasons discussed immediately above. The United States simply cloaks its policy dissatisfaction with this aspect of the statute, and the speculative chilling effect provides no basis for finding that the provision would "essentially nullify" EMTALA's goal of eradicating "patient dumping."

In total, the United States fails to meet its burden to show on its facial challenge that no set of circumstances exists under which Section 18-622 can be lawfully applied. *Wash. State Grange*, 552 U.S. at 449. In fact, it has done the opposite and shown many circumstances in which EMTALA and Idaho's law can operate without conflict. Section 18-622 neither defeats nor nullifies EMTALA's purpose of ensuring that patients receive stabilizing care for an emergency medical condition, including those involving complications to pregnancy. The first, and most important, of the *Winter* factors weighs heavily in Idaho's favor.

# II. Lack of Irreparable Harm

The United States first contends that "allowing the Idaho law to go into effect would threaten severe harm to pregnant patients in Idaho." Dkt. 17-1, at 17. But this assertion does not show irreparable harm to the United States. Nor does Idaho Code § 18-622 threaten harm to Idaho's pregnant women, as the examples provided by the United States' declarations from Drs. Corrigan, Cooper, and Seyb identified situations for which a doctor may exercise good faith medical judgment to determine that an abortion is necessary to preserve the life of the pregnant woman. The Idaho statute does not deprive persons coming to the emergency department "critical emergency care." Indeed, the United States identified approximately 100 cases of ectopic pregnancies in Idaho receiving *Medicaid* covered treatment, but it did not say how many of those were treatments subject to EMTALA; how many of those treatments were abortions; and why the abortions would not be covered under Idaho Code § 18-622's affirmative defense, given that ectopic pregnancy puts a "patient's life in jeopardy... and in the vast majority of cases [will] cause ... potentially fatal internal bleeding." Dkt. 17-3 P 13.

The United States asserts that "emergency medical conditions will occur for a sizeable number of pregnant patients within Idaho." Dkt. 17-1, at 18. It further speculates that physicians

will be discouraged "from providing necessary care in emergency situations." *Id.* It even asserts that "there is a likelihood that some pregnant [women] suffering medical emergencies will face irreversible health consequences," *id.*, but as discussed above, the examples provided by its doctors all fall within Idaho Code § 18-622's good faith medical judgment that abortion was necessary to prevent the death of the pregnant woman. The United States admits this point in just one of many examples (illustrating again why the facial challenge fails), where Dr. Corrigan determined that "termination [of the pregnancy] was necessary to preserve [the woman's] life." Dkt. 17-1, at 19.

Further, one fact that should be reiterated is that EMTALA's scope is narrow—it applies when a person "comes to the emergency department" and ends upon the hospital's provision of the stabilizing treatment or transfer. 42 U.S.C. § 1395dd(a)-(c). EMTALA does not apply to inpatients or outpatients; nor does EMTALA apply outside the context of hospital emergency room treatment—e.g., EMTALA does not apply to an abortion clinic. For this reason, the United States' attempts to assert "injury" unrelated to its claim under EMTALA does not show the need for a preliminary injunction.

#### III. Balance of the Equities and the Public Interest

The United States next contends its sovereign interest is harmed by Idaho regulating abortion—even though the U.S. Supreme Court concluded states were authorized to do just that. Dkt. 17-1, at 19. It says that Idaho is disrupting the Medicare program and depriving the United States of the benefits of its bargain with hospitals. *Id.* Not so. Idaho is regulating abortion through a criminal statute of general applicability, just as it regulates other aspects of offenses that it deems inimical to the public interest. Conversely, it is not regulating Medicare or the hospitals'

participation in Medicare. <sup>10</sup> And contrary to the United States' claim, Idaho is not prohibiting hospitals from "performing EMTALA-mandated services." *Id.* 

Each sovereign operates within its own sphere of responsibility, and if Idaho attempts to invade the area marked out by EMTALA in a particular instance, an aggrieved party has recourse to challenge that alleged overreach. The mere fact that such a dispute may arise in the future does not establish some equitable entitlement to an injunctive net that captures a broad range of entirely lawful state conduct. The equities here are thus evenly balanced, with both governments rightly insisting on preserving their legitimate sovereign interests.

The United States' next contention, that the Idaho law interferes with the provider agreements with the 52 hospitals (although the United States admits only 39 have emergency departments), fares no better. *Id.* at 20. Idaho is not interfering with any terms of the agreements between the hospitals and the United States, as Idaho has simply exercised its police power to regulate abortion. Nothing in the text of Idaho Code § 18-622 purports to interact or interfere with hospitals' provider agreements with the United States.

And here, contrary to the United States' argument, it would be Idaho that would be injured if it were prevented, even in the narrow circumstances of EMTALA, from effectuating the statute enacted by its representatives of the people. *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Rehnquist, J., in chambers). Post-*Dobbs*, the balance of equities and public interest clearly lie in

primarily on whether there is a direct conflict between the EMTALA and Idaho Code § 18-622, which there is not.

willen there is not.

<sup>&</sup>lt;sup>10</sup> In fact, given that approximately \$3.4 billion in Medicare funds went to Idaho hospitals between fiscal years 2018-2020, Dkt. 17-1, at 6, the United States' position that Idaho must alter *its* policy in favor of the United States' policy or have the hospitals risk such funds raises serious concerns that EMTALA's required stabilizing treatment, as interpreted by the United States and expressed in this litigation, is invalid as coercive spending clause legislation. *See Nat'l Fed. of Indep. Buss. v. Sebelius*, 567 U.S. 519, 575-87 (2012). This reason raises another point as to why the United States is not likely to succeed on the merits. But as discussed above, this memorandum focuses

allowing Idaho to regulate abortion as its elected representatives determine best suit the citizenry. *See Ariz. State Legis. v. Ariz. Indep. Redistricting Comm'n*, 576 U.S. 787, 817 (2015) ("This Court has 'long recognized the role of the States as laboratories for devising solutions to difficult legal problems."").

#### **CONCLUSION**

For these reasons, the United States' motion for a preliminary injunction should be denied.

DATED this 16th day of August, 2022.

OFFICE OF THE ATTORNEY GENERAL

By: /s/ Brian V. Church

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#### **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 16th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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# UNITED STATES DISTRICT COURT

# DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

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

Plaintiff,

DECLARATION OF KRAIG WHITE, M.D.

v.

THE STATE OF IDAHO,

Defendant.

I, Kraig White, M.D., declare as follows:

1. I, Kraig White, M.D. am a board-certified family physician at Gritman Medical Center in Moscow, Idaho. For the last 6 years I have worked at this critical care

DECLARATION OF KRAIG WHITE, M.D. - 1

access hospital as an emergency room physician where I have provided care in multiple life-threatening situations that have included obstetrical emergencies. The 11 years prior to working as an emergency room physician, I practiced broad spectrum family medicine that included operative obstetrics. I spent my first 4 years out of residency working with the most underserved through the National Health Service Corps. I completed my family medicine residency training in 2007 at McKay Dee Hospital with the University of Utah. I completed medical school training at the University of Washington in Seattle, WA. I have served on various hospital committees that have included Quality and Safety, Risk Management, Emergency Medicine, Obstetrics, and most recently I finished 9 years of serving on our hospital's board of trustees where I ended by serving as the chairperson. I also have also enjoyed a lengthy history of serving as a clinical preceptor with the University of Washington School of Medicine.

2. I have reviewed the declaration submitted by Dr. Lee A. Fleisher, and the examples he sets forth in his declaration of situations where the conditions presented are of sufficient severity that in the absence of immediate medical attention would reasonably be expected to result in a) 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, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. Dr. Fleisher concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

3. Specifically, Dr. Fleisher refers to a (hypothetical) patient with an ectopic pregnancy and who presents to an emergency department with bleeding, pelvic pain or severe abdominal pain. An ectopic pregnancy, if left untreated, will without exception, place the life of the pregnant woman in extreme jeopardy. Dr. Fleisher states as much: "An ectopic pregnancy in a fallopian tube is an emergency medical condition that places the patient's life in jeopardy because it will cause the fallopian tube to rupture and in the vast majority of cases cause significant and potentially fatal internal bleeding." (Fleisher Declaration at 6.) I agree with Dr. Fleisher that a patient who presents with significant internal bleeding resulting from a ruptured fallopian tube and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

- 4. The next example provided by Dr. Fleisher is of a (hypothetical) pregnant woman who presents to the emergency room with chest pain and severe shortness of breath as a result of severe heart failure related to long-standing pulmonary hypertension. I concur with Dr. Fleisher's observation that "[i]n some circumstances, the appropriate stabilizing treatment for a patient suffering from severe heart failure is treatment of the heart and blood vessels through medications." (Fleisher Dec. at 8.) Dr. Fleisher then posits that "[i]n severe cases, the physician may determine that, despite other medical treatment, the patient continues to have worsening deterioration of blood oxygenation and maintenance of blood pressure." In my opinion, a pregnant patient who presents with continuing deterioration of blood oxygenation in spite of previous, unsuccessful, attempts to manage the condition, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.
- 5. The third example given by Dr. Fleisher is a (hypothetical) patient who presents with nausea and shortness of breath resulting from high blood pressure—symptoms of pre-eclampsia, which in most cases will respond reasonably promptly to medications to control blood pressure. In this example, Dr. Fleisher states, accurately I believe, that "in some cases in which high blood pressure and/or the seizures of severe pre-eclampsia/eclampsia cannot be controlled, termination of the pregnancy is medically

necessary. In such cases, absent termination of the pregnancy, death or severe bodily dysfunction of the pregnant patient is the reasonably probable outcome." In my opinion, a pregnant patient who presents with high blood pressure and seizures attending either preeclampsia or eclampsia, where the high blood pressure and/or seizures have not responded to medication, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

6. Dr. Fleisher's fourth example is of a (hypothetical) patient who presents with a "life-threatening infection of the uterine contents." Here, the conditions set forth in the example are defined as "life-threatening." I agree with Dr. Fleisher's statement that "[t]he infection can progress to sepsis wherein multiple body organs and functions can start failing including the heart, lungs and blood pressure, which could lead to death." In my opinion, a pregnant patient who presents in a state of sepsis and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in

good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

- 7. Dr. Fleisher's fifth example is of a (hypothetical) patient who presents with vaginal bleeding as a result of placental abruption—where the placenta partially or completely separates from the inner wall of the uterus. I agree with Dr. Fleisher's statement that "[p]lacental abruption with uncontrolled and catastrophic bleeding is an emergency medical condition that places the patient's life in jeopardy or can cause serious impairment to bodily functions." Dr. Fleisher concludes that "[i]f bleeding will not stop, then a physician could conclude that the necessary stabilizing treatment for the uncontrolled and catastrophic bleeding includes removal of the fetus or the entire uterus . . . . " In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Recognizing that this example is limited to situations where there is uncontrolled and catastrophic bleeding, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.
- 8. I have reviewed the declaration submitted by Dr. Emily Corrigan, and the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Corrigan present a life-threatening situation. Dr. Corrigan concludes that in each of these

examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the examples provided by Dr. Corrigan present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

9. Dr. Corrigan's first example, Jane Doe 1, was diagnosed with preterm premature rupture of membranes ("PPROM"), or premature breaking open of the amniotic sac. I agree with Dr. Corrigan that PPROM "increases the risk of life-threatening intra-amniotic infection (chorioamnionitis) and also increases the risk that the fetus will not develop normally due to decrease in the amount of amniotic fluid." (Corrigan Declaration at 3.) I also agree with Dr. Corrigan that "[a]dministration of oral antibiotics and discharge home is not the medically accepted standard of care for suspected chorioamnionitis." (Corrigan Declaration at 4.)." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be

my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

- 10. Jane Doe 2 presented to an outlying hospital emergency department experiencing significant bleeding resulting from a placental abruption (separation of the placenta from the wall of the uterus before birth), which progressed to disseminated intravascular coagulation ("DIC"). I agree with Dr. Corrigan that DIC "is a dangerous condition that creates a high risk of death for the mother due to the rapid loss of large volumes of blood." By the time Jane Doe came to Dr. Corrigan for treatment "[t]he risk of her death at that point was imminent and the fetus still had a detectible heart rate." (Corrigan Declaration at p.6.) The pregnancy was terminated by a dilation and evacuation ("D&E") procedure. In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.
- 11. Jane Doe 3 was diagnosed with pleural effusions, sometimes called "water on the lungs," that were being caused by a case of pre-eclampsia with severe features. I

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agree with Dr. Corrigan that [w]hen [preeclampsia] occurs before 20-week's gestation, as it did for Jane Doe 3, it is typically severe and carries a high risk of maternal and fetal death." (Corrigan Declaration at p. 7.) The pregnancy was terminated by a D&E procedure. In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

12. I have reviewed the declaration submitted by Dr. Kylie Cooper, and the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Cooper present a life-threatening situation. Dr. Cooper concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the examples provided by Dr. Cooper present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until

stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

- 13. Dr. Cooper's first example is Jane Doe 1, who presented to the emergency department with severe range blood pressures and whose fetus had already been diagnosed with triploidy, a chromosomal abnormality that leads to multiple severe birth defects that are "not compatible with life." (Cooper Declaration at 3.) Jane Doe was also diagnosed with preeclampsia. I agree with Dr. Cooper that "[g]iven her severe illness placing her at risk for stroke, seizure, pulmonary edema, development of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.
- 14. Dr. Cooper's second example, Jane Doe 2, had a pregnancy complicated by a host of conditions, including severe intrauterine growth restriction, abnormal amniotic fluid level, abnormal umbilical cord blood flow, elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Furthermore, Jane Doe 2's labs quickly deteriorated such that she required a platelet transfusion, had evidence of

hemolysis, and was at risk for DIC ("a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary [and] edema."). (Cooper Declaration at 3-4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

15. Jane Doe 3 presented to the emergency room with acute onset severe abdominal pain, was noted to be hypertensive and her lab abnormalities were consistent with a diagnosis of HELLP syndrome. Also, placental ultrasound was consistent with fetal triploidy, "a lethal fetal condition." Jane Doe 3's abdominal pain and rapidly rising liver enzymes were indicative of liver injury and her platelets were declining rapidly. I agree with Dr. Cooper's assessment that "[i]n the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, [and] pulmonary edema." (Cooper Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the

point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

- 16. I have reviewed the declaration submitted by Dr. Stacy T. Seyb, and the examples he sets forth in his declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Seyb present a life-threatening situation. Dr. Seyb concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the five examples provided by Dr. Seyb present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.
- 17. Dr. Seyb's first example, Jane Doe 1, presented to the emergency department with fever, tender uterus, elevated heart rate and evidence of an intrauterine infection. The suspicion that her bag or water had ruptured 10 days earlier was confirmed by ultrasound that showed no fluid around the baby and confirmed that she had a condition termed Septic

Abortion. I agree with Dr. Seyb's assessment that "[h]ad Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high." (Seyb Declaration at 3.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

18. In Jane Doe 2, Dr. Seyb describes a 35-year-old woman with severe range blood pressure and laboratory values that were consistent with pre-eclampsia with severe features. Also, ultrasound revealed a partial molar pregnancy. I concur with Dr. Seyb's assessment that "[t]he only medically acceptable action to preserve her life was termination of the pregnancy." (Seyb Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I

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could in good faith make the medical judgment that terminating the pregnancy was necessary

to prevent the death of the pregnant woman.

19. Dr. Seyb's third example, Jane Doe 3, presented to the emergency department

"after she started bleeding very heavily per vagina." (Seyb Declaration at 4.) Jane Doe 3

was experiencing hypovolemic shock due to her blood loss, and although "[i]nitial

resuscitation improved her condition, she continued to bleed in an uncontrolled manner."

(Id.) I agree with Dr. Seyb's assessment that "[i]f left untreated the risks of life-threatening

shock, even with blood replacement were very high." In my opinion, a pregnant patient who

presents with the specific conditions described in this example, and whose condition is such

that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-

threatening situation if no treatment was given. Thus, if the conditions in this example have

reached the point that it is not safe to transfer the patient until stabilizing treatment is given,

it would be my good faith medical opinion that termination of the pregnancy was necessary

to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I

could in good faith make the medical judgment that terminating the pregnancy was necessary

to prevent the death of the pregnant woman.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of

the United States of America that the foregoing is true and correct.

DATED this 16th day of August, 2022.

/s/ Kraig White, M.D.

KRAIG WHITE, M.D.

#### **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 16th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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Attorneys for Defendant State of Idaho

# UNITED STATES DISTRICT COURT

## DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Case No. 1:22-cv-329

Plaintiff,

DECLARATION OF RANDY RODRIQUEZ

v.

THE STATE OF IDAHO,

Defendant.

- I, Randy Rodriquez, declare as follows:
- 1. I am the Hospital Administrator for State Hospital South in the Idaho Department of Health and Welfare's (IDHW) Division of Behavioral Health. My duties and

DECLARATION OF RANDY RODRIQUEZ - 1

responsibilities include the overall management and operation of the hospital. I have held this position since November 16, 2020. Before that, I was Human Services Field Program Manager, Clinical Supervisor and Clinician. I have worked at IDHW since 1998.

- 2. State Hospital South is a psychiatric hospital that provides skilled nursing and adult inpatient psychiatric care. It is Idaho's only state hospital that has entered into Medicare and Medicaid provider agreements to receive federal funding for the provision of care and services.
- 3. State Hospital South has no specialized capabilities or facilities related to the treatment of conditions that would require abortion, or that would require it to accept the transfer of a patient for an abortion.
- 4. State Hospital South is not licensed by the State of Idaho as an Emergency Room or Emergency Department.
- 5. State Hospital South does not have, nor does it hold itself out to the public as having, emergency facilities that provide care or treatment for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- 6. Because State Hospital South is a psychiatric hospital, it would be outside the standard of care for medical providers at State Hospital South to perform an abortion as immediate stabilizing treatment. In the event a patient at State Hospital South were medically assessed to require an abortion as stabilizing treatment, the patient would have to be transferred to another facility.
- 7. I have reviewed the declaration of David R. Wright. Based on my knowledge and experience as the administrator of State Hospital South and the statement in paragraphs 10 through 12 of Mr. Wright's Declaration, State Hospital South does not have any

obligations under the Emergency Medical Treatment and Labor Act that would result in it performing an abortion under any scenario.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

DATED this 16th day of August, 2022.

/s/ Randy Rodriquez
RANDY RODRIQUEZ, Declarant

#### **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 16th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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/s/ Brian V. Church
BRIAN V. CHURCH
Deputy Attorney General

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-00329-BLW

MEMORANDUM DECISION AND ORDER

#### INTRODUCTION

Before the Court is a motion to intervene filed by the Idaho Legislature (Dkt. 15). For the reasons expressed below, the Court will grant the motion in part and deny it in part. The Court will deny the motion to the extent the Legislature seeks to intervene as of right. But the Court will grant permissive intervention on a limited basis to allow the Legislature to present argument and evidence (including witnesses) in opposition to the United States' pending Motion for Preliminary Injunction. As explained further below, the Legislature's participation will be limited to presenting evidence and arguments the Legislature has said will show "the holes in the 'factual' foundation" of the United States' motion. *See Legislature's Reply Br.*, Dkt. 25, at 6. Thus, the Legislature will be allowed to participate in the preliminary-injunction proceedings only – and in that limited

MEMORANDUM DECISION AND ORDER - 1

fashion. Otherwise, if during the course of this litigation the facts develop such that it becomes clear the State and Legislature's interests diverge, and the State can no longer adequately represent the Legislature's interests, the Court will entertain a renewed motion to intervene.

### **BACKGROUND**

In 2020, the Idaho Legislature passed a law making it a felony for anyone to perform or attempt to perform or assist with an abortion. Idaho Code § 18-622(2). This law allows for affirmative defenses to prosecution where the abortion is necessary to prevent the death of a pregnant woman, or the pregnancy resulted from rape or incest that was reported to law enforcement. *Id.* § 18-622(3) (the "Total Abortion Ban.") Idaho Governor Brad Little signed the bill, but the Total Abortion Ban did not become law when signed. Rather, recognizing the constitutional impediments presented by *Roe v. Wade*, 410 U.S. 113 (1973), the bill contained a provision – commonly referred to as a "trigger" – stating that the prohibition would take effect 30 days following "[t]he issuance of the judgment in any decision of the United States supreme court that restores to the states their authority to prohibit abortion . . . ." Idaho Code § 18-622(1)(a).

On June 24, 2022, the United States Supreme Court handed down *Dobbs v*. *Jackson Women's Health Organization*, 142 S. Ct. 2228 (June 24, 2022), overruling *Roe* and holding that the "Constitution does not prohibit the citizens of

each State from regulating or prohibiting abortion." 142 S. Ct. at 2284. The Supreme Court's decision in *Dobbs* triggered the Total Abortion Ban, which is now set to go into effect on August 25, 2022.

Governor Little has consistently offered his full-throated support for *Roe's* overruling and for Idaho's Total Abortion Ban. In July 2021, he joined ten other governors submitting an *amicus* brief in *Dobbs*, arguing that *Roe* should be overturned and regulation of abortion should be returned to the states. (Idaho Attorney General Lawrence Wasden also joined more than 20 other attorneys general in a similar *amicus* brief.) And on the same day the Supreme Court issued *Dobbs*, Governor Little issued a press release lauding the decision and commenting that Idaho's Total Abortion Ban would take effect later this summer:

I join many in Idaho and across the country today in welcoming the high court's long awaited decision upholding state sovereignty and protecting preborn lives. The decision provides clarity around landmark cases at the center of passionate debate in our country for nearly five decades. This is now clear – the 'right' to an abortion was a judicial creation. Abortion is not a right expressed in the U.S. Constitution, and abortion will be entrusted to the states and their people to regulate.

Idaho has been at the forefront of enacting new laws to protect preborn babies. The pro-life bill I signed into law in 2020 will go into effect later this summer.

Today's decision is the culmination of pro-life efforts to defend the defenseless – preborn babies who deserve protection. It also is affirmation of states' rights, a fundamental aspect of our American

government.1

Waiting six weeks from the issuance of *Dobbs*, and with only three weeks until the Total Abortion Ban is due to take effect, the United States of America filed this case against the State of Idaho on August 2, 2022. The United States challenges the constitutionality of the Total Abortion Ban on the grounds that it violates the Supremacy Clause and is preempted to the extent it is contrary to the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. The United States seeks to enjoin the statute's taking effect on August 25, 2022.

The tight timeline between the United States' filing its complaint and the law's effective date necessitated the parties agree to an expedited brief schedule. The schedule proposed by the parties, and which the Court adopted, provided for the United States to file its preliminary injunction motion on August 8, the State to file its response on August 16, and the United States to file its reply on August 19 by noon Mountain Daylight Time. *Order*, Dkt. 13. The Court has scheduled the hearing on the motion for August 22, 2022.

Shortly before the United States filed its Motion for Preliminary Injunction, on the evening of August 8, the Legislature moved to intervene as an intervenor-

<sup>&</sup>lt;sup>1</sup> Gov. Little Comments on SOCUTS Overrule of Roe v. Wade, dated June 24, 2022, <a href="https://gov.idaho.gov/pressrelease/gov-little-comments-on-scotus-overrule-of-roe-v-wade/">https://gov.idaho.gov/pressrelease/gov-little-comments-on-scotus-overrule-of-roe-v-wade/</a> (last visited Aug. 13, 2022).

defendant pursuant to Federal Rule 24(a) or Rule 24(b). The Legislature seeks to intervene because, it argues, Idaho law and Rule 24 allow it to intervene as of right in any actions challenging the constitutionality of a state law, and the State will not adequately represent all of the Legislature's interests in this litigation. If denied the opportunity to intervene, it further requests permission to file an *amicus curiae* brief and participate in the August 22 hearing.

The United States does not oppose the Legislature's participation in this case as an *amicus curiae*, and it further states that it does not oppose the State's ceding some of its oral argument time to the Legislature if the State chooses to do so. But the United States opposes the Legislature's intervention on the basis that the Legislature has failed to identify any divergence between its interests and the interests of the State in this case and has failed to provide any justification that its intervention would aid the Court's decision in this case. The United States further argues that the Legislature's intervention would prejudice the United States under the expedited briefing schedule unless the Court were to take steps to mitigate the prejudice.

# **LEGAL STANDARD**

The Federal Rules of Civil Procedure permit a party to intervene as of right under Rule 24(a) and permissively under Rule 24(b). *Cooper v. Newsom*, 13 F.4th 857, 864 (9th Cir. 2021). An applicant for intervention as of right must satisfy four

criteria under Rule 24(a)(2): "(1) the application for intervention must be timely; (2) the applicant must have a 'significantly protectable' interest relating to the property or transaction that is the subject of the action; (3) the applicant must be so situated that the disposition of the action may, as a practical matter, impair or impede the applicant's ability to protect that interest; and (4) the applicant's interest must not be adequately represented by the existing parties in the lawsuit." *Animal Legal Def. Fund v. Otter*, 300 F.R.D. 461, 464 (D. Idaho 2014) (citing *Southwest Center for Biological Diversity v. Berg*, 268 F.3d 810, 817 (9th Cir. 2001)); *see also Oakland Bulk & Oversized Terminal, LLC v. City of Oakland*, 960 F.3d 603, 620 (9th Cir. 2020) (citing Fed. R. Civ. P. 24(a)(2)).

"In evaluating whether these requirements are met, courts are guided primarily by practical and equitable considerations." *Callahan v. Brookdale Senior Living Cmty., Inc.,* --- F.4th ---, 2022 WL 3016027, at \*5 (9th Cir. June 29, 2022) (internal quotation marks and citation omitted). Although courts construe Rule 24(a) broadly in favor of proposed intervenors, *id.*, an applicant seeking intervention bears the burden of proving that these requirements are met. *Citizens for Balanced Use v. Mont. Wilderness Ass'n*, 647 F.3d 893, 897 (9th Cir. 2011). Failure to satisfy any one of the requirements is fatal to the application." *Perry v. Prop. 8 Official Proponents*, 587 F.3d 947, 950 (9th Cir. 2009).

By contrast, permissive intervention under rule 24(b) requires only that the

proposed intervener "have a question of law or fact in common" with the underlying action, that the request be timely made, and that the court have an independent basis for jurisdiction over the proposed intervener's claims.

Fed. R. Civ. P. 24(b). When ruling on a motion for permissive intervention under Rule 24(b), a district court "must consider whether the intervention will unduly delay or prejudice the adjudication of the original parties' rights." *Dep't of Fair Emp. & Hous. v. Lucent Techs., Inc.*, 642 F.3d 728, 741 (9th Cir. 2011) (quoting Fed. R. Civ. P. 24(b)). "Even if an applicant satisfies those threshold requirements, the district court has discretion to deny permissive intervention." *Cooper*, 13 F.4th at 868.

#### **ANALYSIS**

When an applicant moves to intervene in a pending lawsuit under Federal Rule of Civil Procedure 24(a)(2), a federal court has no authority to grant the motion if an existing party to the case adequately represents the movant's interests. Fed. R. Civ. P. 24(a)(2). Here, the Legislature has failed to meet its burden of showing that the State will not adequately represent its interests in the litigation. The Legislature's failure to satisfy this requirement is fatal to its application for intervention as of right. *Perry*, 587 F.3d at 950.

As already noted, however, the Court will allow the Legislature to intervene on a limited basis, as explained in further detail below.

#### **MEMORANDUM DECISION AND ORDER - 7**

# 1. Intervention as a Matter of Right

A movant seeking intervention typically bears a "minimal" burden of showing inadequacy of representation by an existing party, and such burden is satisfied if the applicant can demonstrate that representation of its interests may be inadequate. Berger v. N. Carolina State Conf. of the NAACP, 142 S. Ct. 2191, 2205 (2022) (quoting Trbovich v. United Mine Workers, 404 U.S. 528, 538 n.10 (1972)). In Berger, the Supreme Court addressed a request by two leaders of North Carolina's state legislature to intervene in a federal lawsuit challenging a voteridentification law and explained what it takes to meet this "minimal" burden. There, the NAACP sued Executive Branch officials sympathetic to its position namely, the Governor, who had vetoed the law after its passage and continued to actively oppose it, and members of the State Board of Elections (collectively, the "Board"), who were appointed and potentially removable by the Governor. Id. at 2198. The state's attorney general assumed responsibility for defending the Governor and the Board. *Id.* Like the Governor, the attorney general had opposed an earlier voter-ID law and participated in a legal challenge against it. *Id.* Further, the North Carolina attorney general's office had a history of opposing laws enacted by the legislature and declining to fully defend those laws in federal litigation. *Id.* at 2197.

After the NAACP sued these officials in Berger, two legislative leaders

moved to intervene on behalf of the state legislature, arguing, inter alia, that "without their participation, important state interests would not be adequately represented in light of the Governor's opposition to [the bill], the Board's allegiance to the Governor, and the attorney general's opposition to earlier voter-ID efforts." *Id.* They also claimed the Board had offered only a "tepid" defense of the law in a parallel state-court proceeding. *Id.* at 2198-99. The district court denied their motion without prejudice and again denied their renewed motion. *Id.* at 2199.

As the litigation proceeded without the legislative leaders, the NAACP moved to enjoin the Board from enforcing the voter-ID law in the upcoming litigation; by this time, the Governor had been dismissed from the suit, and only the Board members, represented by the attorney general, remained as defendants. *Id.* The legislative leaders, unsatisfied with the vigor of the Board's response to the request for injunctive release, sought to lodge an *amicus* brief, five expert reports, and several other declarations. *Id.* "At the end of the day, however, the District Court refused to consider the amicus brief and accompanying materials, struck them from the record, and granted a preliminary injunction barring enforcement of [the voter-ID law]." *Id.* 

The legislative leaders appealed the ruling denying intervention. The Board also appealed the ruling granting the preliminary injunction but did not seek a stay

of the injunction because of "disruptive effect such relief would have had on election administration." *Id.* (internal quotation marks omitted). The law was therefore not enforced during the state's March 2020 primary election. *Id.* at 2200. Meanwhile, the Governor had filed an *amicus* brief in the appeal in favor of the injunction, arguing that the district court "had not gone far enough." *Id.* But the Fourth Circuit ultimately side with the legislative leaders with respect to the injunction, who had also filed an *amicus* brief opposing it, finding the district court had abused its discretion in issuing the injunction. The Fourth Circuit, however, affirmed the district court's denial of intervention in an *en banc* decision. The Supreme Court granted certiorari.

The Supreme Court reversed the Fourth Circuit's *en banc* decision, holding North Carolina's legislative leaders were entitled to intervene in the litigation. In so holding and "[c]asting aspersions on no one," the Court observed, "this litigation illustrates how divided state governments sometimes warrant participation by multiple state officials in federal court. *Id.* at 2205. It explained how the legislative leaders requesting to intervene sought to give voice to a perspective different from that of the Board – which remained beholden to a Governor that had vetoed the law at issue and who had filed his own briefs in the litigation, "calling the law 'unconstitutional' and arguing that it 'should never go into effect," and which at all times had been represented by an attorney general

who publicly opposed an earlier version of the law. Critically, the Board had also conceded in the parallel state-court proceedings "that its 'primary objective' wasn't defending [the law], but obtaining guidance regarding which law it would need to enforce in an upcoming election ([the current law being challenged] or preexisting law)." *Id.* at 2199. Thus, the Board, more concerned about the state's interest in "stability and certainty," had aimed its focus in the litigation on obtaining guidance for the administration of upcoming elections – instead of focusing wholeheartedly on defending the law from the constitutional challenge. *Id.* 

By contrast, the legislative leaders remained unburdened "by misgivings about the law's wisdom" and, if allowed to intervene, had pledged to focus solely on "defending the law vigorously on the merits, without an eye to crosscutting administrative concerns" – concerns that had plagued the Board's defense throughout the litigation. *Id.* This "unalloyed interest in vindicating the law from constitutional challenge," *id.* at 2196, the Supreme Court reasoned, set the legislative leader's interests apart from the interests of the Board, who were more concerned with election administration than defending the law. *Id.* at 2205.

Because the legislative leaders had shown that they sought to vindicate valuable state interests distinct from the Board's interests – and had further shown that the Board's preoccupation with administrative concerns and its allegiance to a Governor, who opposed the law, prevented it from adequately representing those

distinct interests – the Supreme Court held that the legislative leaders had a right to intervene in the litigation. *Id*.

In this case, unlike in *Berger*, the Legislature has failed to show that it brings a distinct state interest to bear on this litigation that the State cannot adequately represent – even given the Legislature's minimal burden. As just discussed, in Berger, the legislative leaders provided evidence that the existing state defendants' "primary objective" in the litigation differed from their own and that existing state defendant's preoccupation with these other interests, together with their misgivings about the wisdom of the law, prevented them from providing a full-throated defense of the law on the merits. But no such concerns exist here. The Idaho Legislature can point to no evidence that the State, represented by the Attorney General, has expressed any misgivings about the Total Abortion Ban, or that the State is concerned with interests distinct from the Legislature's that would prevent it from focusing solely on "defending the law vigorously on the merits," without an eye to other concerns. Nor has the Attorney General ever publicly opposed the Total Abortion Ban or a similar law, and nothing otherwise indicates that he would decline to defend it. To the contrary, all signs lead to the conclusion that not only does the State assert "an unalloyed interest" in vindicating the law from constitutional challenge, indicating it will offer the most robust defense of the law, but also that the State and Legislature's interests are fully aligned in this litigation.

Despite this reality, the Legislature claims that it has a "unique interest, the interest that is really at stake here—its unique power and authority and duty to answer the hard questions posed by abortion," such as "What is the moral value of a preborn child?," or "In what situations are the mother's interests more weighty than the moral value and interests of the preborn child?" Legislature's Reply Br., Dkt. 25, at 8 (emphasis in original). The Legislature maintains only it can answer these questions, and not the executive branch. Id. But the United States has not sued any executive branch officials; instead, it has sued the State, and the Legislature utterly fails to explain how it is uniquely positioned – separate and apart from the State – to answer these questions. The Legislature's criticism of the Executive Branch in this case is particularly puzzling given Governor Little's statements unequivocally supporting the *Dobbs* decision and the Total Abortion Ban. Likewise, as noted, all indications suggest that the Attorney General remains fully on board in defending the law.

In fact, to this point, the Legislature has presented no credible argument that it itself is distinct from the "the State," either formally or functionally for purposes this litigation, and therefore a "new" party entitled to intervene under Rule 24(a). Again, this case is distinguishable from *Berger* in that the United States has not sued particular officers of the State but rather the State itself. As the United States argues, "[b]y virtue of being part of the State of Idaho itself, the Idaho Legislature

is already a party, and the Legislature articulates no reason why this Court should grant intervention when the State is already a party. United States Resp. at 6, Dkt. 23 (citing Berger, 142 S. Ct. at 2203) (rejecting the argument that "the legislative leaders are already effectively 'existing' parties to this suit" because the plaintiff "has not sued the State"). And, critically, as the United States also points out, because the State itself is the defendant, the practical concerns animating Berger do not exist here: there is no risk United States has "select[ed] as their defendants those individual officials [it] consider[s] most sympathetic to [its] cause or most inclined to settle favorably and quickly." Id. at 2201. Indeed, even if the United States tried, it is difficult to see what state official it could have picked who it may have considered more sympathetic to its cause or who would have been more inclined to settle this case favorably and quickly. In this case, the State appears fully united thus far.

In sum, the Court finds the circumstances of this case readily distinguishable from *Berger* and further finds that the Legislature has failed to show it seeks "to give voice to a different perspective" than the State's, or that the State will not adequately represent the Legislature's interests. Even as it is, *Berger* will make litigation in federal court involving states far more burdensome. As Justice Sotomayer noted in her dissent, "[i]t is difficult to overstate the burden the Court's holding [in *Berger*] will foist on district courts." *Id.* at 2211. But to ignore

distinctions between this case and <code>Berger</code> – and to allow a legislature the right to intervene in every federal case whenever it says it should be allowed to do so <code>and</code> without requiring the legislature to meet even its minimal burden of showing it possesses a distinct interest or that its interests are inadequately represented – would allow a state to turn into a nine-headed Hydra whenever it so chooses. This Court does not read <code>Berger</code> as intending or permitting such a result in a case such as this one – where not a speck of evidence exists that the State and the Legislature's interests diverge in any real and practical sense. This Court therefore finds that the Legislature has shown no right to intervene in this case – at least at this stage in the litigation.

As explained below, however, the Court will allow the Legislature to permissively intervene for the limited purpose of opposing the United States' motion for preliminary injunction, including an opportunity to present witnesses at the August 22 hearing if it so chooses.

#### 2. Permissive Intervention

"A district court may grant permissive intervention under Rule 24(b)(1)(B) where the applicant shows (1) independent grounds for jurisdiction; (2) the motion is timely; and (3) the applicant's claim or defense, and the main action, have a question of law or a question of fact in common." *Perry*, 587 F.3d at 955 (internal quotation marks and citation omitted). "Where a putative intervenor has met these

requirements, the court may also consider other factors in the exercise of its discretion. *Id.* "These relevant factors include the nature and extent of the intervenors' interest, their standing to raise relevant legal issues, the legal position they seek to advance, and its probable relation to the merits of the case." *Spangler v. Pasadena City Bd. of Ed.*, 552 F.2d 1326, 1329 (9th Cir. 1977). The Court may also consider "whether the intervenors' interests are adequately represented by other parties" and "whether parties seeking intervention will significantly contribute to full development of the underlying factual issues in the suit and to the just and equitable adjudication of the legal questions presented." *Id.* 

"When making this discretionary determination, a district court 'must consider whether the intervention will unduly delay or prejudice the adjudication of the original parties' rights." *Lucent*, 642 F.3d at 741(quoting Fed. R. Civ. P. 24(b)(3)). "The district court's discretion under Rule 24(b), to grant or deny an application for permissive intervention includes discretion to limit intervention to particular issues." *Id.* (quoting *Van Hoomissen v. Xerox Corp.*, 497 F.2d 180, 181 (9th Cir.1974) (internal quotation marks and ellipses omitted).

Here, the Court finds that the Legislature's motion is timely and that its

Proposed Answer reflects defenses that present common issues of fact and law. As
the Legislature has met the threshold requirements for permissive intervention, the
Court may consider other factors in its discretion, including whether the

Legislature "will significantly contribute to full development of the underlying factual issues in the suit and to the just and equitable adjudication of the legal questions presented." *Spangler*, 552 F.2d at 1329.

In its reply brief, the Legislature says it would call witnesses at the preliminary injunction hearing to present evidence of whether "Relevant Abortions" are "occurring in Idaho's Medicare-funded emergency rooms," but the State may not. *Legislature's Reply* at 5, Dkt. 25. While the Court – in light of the evidence it currently has before it – would not consider the State's decision not to call witnesses at the preliminary injunction hearing on this narrow factual question a reason to justify the Legislature's intervention as of right, it nonetheless finds that that justifies the Legislature's permissive intervention *on this sole issue*. *Lucent*, 642 F.3d at 741 (limiting intervention to discrete issues).

The Legislature may therefore permissively intervene, but it will be limited at this juncture to presenting argument and evidence in opposition to the United States' motion for preliminary injunction. More specifically, the Legislature's participation in the preliminary-injunction proceedings will be limited to allowing

<sup>&</sup>lt;sup>2</sup> The Legislature defines "Relevant Abortions" as "those emergency-room abortions that fall (i) inside the prohibition of abortion found in Idaho Code § 18-622 ("the 622 Statute") and (ii) outside the overlap between the 622 Statute's medical-emergency exception and EMTALA's medical-emergency mandate but still inside EMTALA's mandate." *Legislature's Reply* at 2, Dkt. 25.

it to show "the holes in the 'factual' foundation" of the motion on the issue of "Relevant Abortions," as the Legislature has specifically laid out in its reply. Legislature's Reply, 6-7, Dkt. 25 (describing the Legislature's "present litigation plan"). The Court, of course, will allow the Legislature to modify its proposed plan in responding to the preliminary injunction motion on this particular issue as the Legislature sees fit. But the larger point is that, substantively, the Legislature's participation will be limited to allowing it to present evidence and argument aimed at "showing the holes" in the factual foundation of the United States' motion.

Lastly, the Court cannot ignore the issue of whether the Legislature's permissive intervention "will unduly delay or prejudice the adjudication of the original parties' rights." The United States argues that granting the Legislature will prejudice it because it negotiated the briefing schedule with the State under the assumption they would be the only parties in the case – and the "briefing schedule is extraordinarily expedited in light of the impending effective date of the challenged law." *United States' Resp.*, Dkt. 23, at 8. The United States claims that the Legislature's intervention at this juncture would be unfair because "the United States would need to respond to two opposition briefs of up to 20 pages each (plus an unknown number of factual submissions), but would, under the briefing schedule, have only two and a half days (and ten pages) to do so." *Id.* 

First, the Court notes that any prejudice to the United States stemming from

the briefing schedule is largely of the United States' own making. It chose to delay filing this case and its motion for preliminary injunction for over six weeks after the Supreme Court issued the *Dobbs* decision. Nonetheless, the Court acknowledges that the Legislature's intervention may cause some prejudice to the United States. To mitigate that prejudice, the Court has limited the Legislature by subject matter, as already explained.

Further, in terms of briefing deadlines, the Court will adopt this schedule:

- (1) The Legislature must file its brief on **August 16, 2022** which is the same day the State's brief is due. If the Legislature intends to present affidavits, any such affidavits shall likewise be due on **August 16, 2022**.
- (2) The United States must file its optional combined reply brief addressing both the State's and the Legislature's briefing by the existing reply deadline of 12:00 p.m. Mountain Time on August 19, 2022.

As for page limitations, the State will be permitted 20 pages, and the Legislature 15. The United States will be allowed 20 pages for its combined reply brief.

Finally, in an effort to ensure that the preliminary-injunction proceedings are efficient and streamlined, the Court will not allow the State and the Legislature to pursue duplicative strategies during the preliminary-injunction proceedings. More

specifically, during an informal conference, the State indicated it views the United States' motion as presenting purely legal questions. The Legislature, on the other hand, says it is "prepared to present evidence countering the Government's position on the material issues of fact." *Legislature Reply Br.* Dkt. 25, at 5.

Accordingly, to the extent that the Legislature intends to present factual evidence (or challenge the United States' factual submissions) – including by calling witnesses – the Court will not allow the State to duplicate those efforts.

### **ORDER**

IT IS ORDERED that the Idaho Legislature's Motion to Intervene (Dkt. 15) is GRANTED in part and DENIED in part, as explained above.

COLUMNS

DATED: August 13, 2022

B. Lynn Winmill

U.S. District Court Judge

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## UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

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

MOTION FOR A PRELIMINARY INJUNCTION

# THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

Plaintiff the United States of America respectfully moves for a preliminary injunction against the State of Idaho—including all of its officers, employees, and agents—prohibiting enforcement of Idaho Code § 18-622(2)-(3) as applied to EMTALA-mandated care. The United States' arguments in support of this motion are fully set forth in the attached memorandum of law and supporting declarations.

Dated: August 8, 2022

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### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

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

v.

THE STATE OF IDAHO,

Defendant.

MEMORANDUM IN SUPPORT OF MOTION FOR A PRELIMINARY INJUNCTION

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#### INTRODUCTION

Federal law requires certain hospitals receiving federal Medicare funds to offer treatment to individuals experiencing medical emergencies. Under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, individual patients must be provided "stabilizing care" when they seek treatment at a covered hospital for an "emergency medical condition." An emergency medical condition exists when a patient's "health" is in "serious jeopardy" or the patient risks "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A). Some patients who experience these medical emergencies are pregnant, and in some situations the necessary stabilizing treatment for such a pregnant patient involves termination of the pregnancy. In those circumstances, EMTALA requires that hospitals offer that stabilizing treatment to the patient, who can then decide whether to proceed.

In direct conflict with this federal requirement, the State of Idaho has enacted a near-absolute ban on abortion that is scheduled to go into effect on August 25, 2022. See Idaho Code § 18-622 (2020). Under Idaho's law, any physician who terminates a pregnancy can be indicted, arrested, and prosecuted on felony charges, regardless of the medical need for the procedure. A physician may avoid criminal liability only by proving a narrow "affirmative defense"—as relevant here, that the abortion was "necessary to prevent the death of the pregnant woman." Id. § 18-622(3)(a)(ii). That defense is far narrower than the circumstances in which EMTALA requires providing stabilizing treatment. Where EMTALA's standard is met but the treatment is not strictly "necessary to prevent the death" of the patient, it is impossible for a physician to comply both with the obligations of EMTALA and § 18-622. And even in cases where termination of the pregnancy is necessary to prevent the patient's death, the Idaho law requires a physician to risk arrest and prosecution for each abortion performed because the law affords only an "affirmative defense" that the physician must prove at trial. By threatening physicians with criminal prosecution—even when they provide treatment in emergency, life-

threatening situations as federal law requires—Idaho's law penalizes and discourages such treatment, and thereby conflicts directly with federal law. In these respects, federal law preempts § 18-622.

If allowed to go into effect, the Idaho law will cause significant irreparable harm, including to the public health of patients across Idaho. As the declaration of Dr. Lee A. Fleisher (attached as Ex. A) demonstrates, there are emergency conditions affecting pregnant individuals for which the medically necessary treatment involves termination of the pregnancy. But § 18-622 criminalizes providing such treatment, despite the extremely serious risk that, for example, a patient with an ectopic pregnancy might bleed to death, an infection could turn into sepsis and cause organ failure, or seizures caused by eclampsia might prove uncontrollable. Physicians practicing within Idaho likewise confirm that, if § 18-622 takes effect, pregnant patients experiencing emergency conditions will suffer. See Decls. of Dr. Emily Corrigan, Dr. Kylie Cooper, and Dr. Stacy T. Seyb (attached hereto as Exs. B-D). These facts establish clear irreparable harm and a strong public interest in enjoining § 18-622 from going into effect as applied to EMTALA-mandated care. The Court should grant the United States' motion for a preliminary injunction.

### **BACKGROUND**

### I. Federal Law

### A. Supremacy of Federal Law

The Supremacy Clause of the U.S. Constitution mandates that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Pursuant to that principle, "states have no power . . . to retard, impede, burden, or in any manner control the operations of the Constitutional laws enacted by [C]ongress to carry into effect the powers vested in the national government." *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 317 (1819).

When "Congress enacts a law that imposes restrictions or confers rights on private actors," and "a state law confers rights or imposes restrictions that conflict with the federal law," the "federal law takes precedence and the state law is preempted." *Murphy v. NCAA*, 138 S. Ct. 1461, 1480 (2018). If a "statute contains an express pre-emption clause, we do not invoke any presumption against pre-emption but instead focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *Puerto Rico v. Franklin Calif. Tax-Free Tr.*, 579 U.S. 115, 125 (2016) (citation omitted).

### B. The Emergency Medical Treatment and Labor Act (EMTALA)

Medicare is a federally funded program, administered by the Secretary of Health and Human Services (HHS), that generally pays health care providers for health care services under certain circumstances. See 42 U.S.C. § 1395 et seq. Participation in Medicare is voluntary, and each provider must submit an agreement to the Secretary promising to comply with certain conditions in return for receipt of Medicare funding. See id. § 1395cc. Although Medicare generally does not contemplate Federal employees "exercis[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided," 42 U.S.C. § 1395, that does not prevent the Federal Government from establishing and enforcing conditions of participation in Medicare, see Biden v. Missouri, 142 S. Ct. 647, 654 (2022), nor does it eliminate Congress's "broad power under the Spending Clause of the Constitution to set the terms on which it disburses federal funds." Cummings v. Premier Rehab Keller, PLLC, 142 S. Ct. 1562, 1568 (2022).

Congress enacted EMTALA in 1986, based on "a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 99-241, Part 3, at 5 (1985); see also Arrington v. Wong, 237 F.3d 1066, 1073-74 (9th Cir. 2001) ("The overarching purpose of EMTALA is to ensure that patients, particularly the indigent and underinsured, receive adequate emergency medical care." (alterations and citations

omitted)). EMTALA applies to every hospital that has an emergency department and participates in Medicare, *see* 42 U.S.C. § 1395dd(e)(2), regardless of whether any particular patient qualifies for Medicare. Congress has statutorily required that hospitals participating in Medicare agree to comply with EMTALA as a condition of receiving federal funding. *See id.* § 1395cc(a)(1)(I)(i).

Under EMTALA, when a patient arrives at an emergency department and requests treatment, the hospital must provide an appropriate medical screening examination "to determine whether or not an emergency medical condition" exists. *Id.* § 1395dd(a); *see also* 42 C.F.R. § 489.24(a)(1)(i). Congress defined an "emergency medical condition" as:

- (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 ...
- (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.

42 U.S.C. § 1395dd(e)(1). If a hospital determines that an 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" certain requirements. *Id.* § 1395dd(b)(1); *see also* 42 C.F.R. § 489.24(a)(1)(ii). The hospital may also "admit[] th[e] individual as an inpatient in good faith in order to stabilize the emergency medical condition." 42 C.F.R. § 489.24(d)(2)(i). Under EMTALA, "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). "[T]ransfer" is defined to include discharge of a patient. *Id.* § 1395dd(e)(4). A hospital satisfies its obligations under EMTALA if, after being informed of the risks and benefits of treatment, the patient (or the patient's representative) does not consent to the treatment. *Id.* § 1395dd(b)(2).

In short, EMTALA requires that hospitals offer stabilizing treatment where "the health" of the patient is "in serious jeopardy," or where a condition could result in a "serious impairment to bodily functions" or a "serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1)(A)(i)-(iii). The hospital may also "transfer" such an individual, but only if the transfer meets certain requirements, *e.g.*, that the medical benefits of the transfer outweigh the risks. *Id.* § 1395dd(c)(1)(A)(ii).

EMTALA contains an express preemption provision, preserving state laws "except to the extent that the requirement directly conflicts with a requirement of this section." *Id.* § 1395dd(f). The intent of this provision was to preserve "stricter state laws," *i.e.*, state laws requiring emergency care *beyond* what EMTALA mandates. H.R. Rep. No. 99-241, Part 1, at 4 (1985); *see also* H.R. Rep. No. 99-241, Part 3, at 5 (1985) (expressing a desire to add "federal sanctions" as a supplement to state law duties "to provide necessary emergency care"); *Harry v. Marchant*, 291 F.3d 767, 773-74 (11th Cir. 2002). For purposes of EMTALA, "[a] state statute 'directly conflicts' with federal law in either of two cases: first, if 'compliance with both federal and state regulations is a physical impossibility,' or second, if the state law is 'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (citations omitted) (per curiam); *accord Hardy v. N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789, 795 (2d Cir. 1999).

# C. Idaho Hospitals' Participation in Medicare and Their Agreements to Comply with EMTALA Obligations

As noted, a hospital participating in Medicare must comply with EMTALA as a condition of receiving federal funds. *See* 42 U.S.C. § 1395cc(a)(1)(I)(i). Additionally, hospitals enter into written agreements with the Secretary confirming they will comply with EMTALA.

Hospitals apply to become certified under Medicare by submitting a Centers for Medicare & Medicaid Services (CMS) Form 855, see Decl. of David R. Wright (attached hereto as Ex. E) ¶ 2, in which the provider "agree[s] to abide by the Medicare laws, regulations and program instructions that apply." CMS Form 855, § 15, ¶ A.3 (pg. 48), https://perma.cc/84T6-S2DP. If approved for Medicare certification, the hospital must then sign CMS Form 1561, Wright Decl. ¶ 4, in which the provider likewise "agrees to conform to the provisions of section of 1866 of the Social Security Act [42 U.S.C. § 1395cc] and applicable provisions in 42 CFR." https://perma.cc/5EPE-YLRE. Finally, each fiscal year, a Medicare-participating hospital must submit a cost report, pursuant to which "the Chief Financial Officer or hospital Administrator must certify that he or she is 'familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations,' which include EMTALA." Wright Decl. ¶ 6; see also Decl. of Barbara Shadle (attached hereto as Ex. F) ¶¶ 2-5.

Within Idaho, there are 52 Medicare-certified hospitals, at least 39 of which provide emergency services. Wright Decl. ¶ 8. Of the 52 hospitals, 16 are government-owned, and at least 15 of those provide emergency services. *Id.* ¶ 9. These 52 hospitals in Idaho received approximately \$3.4 billion in federal Medicare funds during fiscal years 2018-2020; by rough estimate, approximately \$74 million was attributable to these hospitals' emergency departments. Shadle Decl. ¶ 6. That funding was conditioned on compliance with EMTALA. Wright Decl. ¶ 14.

### II. Idaho's Abortion Law

In 2020, Idaho enacted a law that severely restricts abortion and threatens criminal prosecution against anyone who performs the procedure. The law, codified at Idaho Code § 18-622, is set to take effect August 25, 2022. *See* Idaho Code § 18-622(1)(a).

Under § 18-622, "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion," a felony punishable by two to five years imprisonment. *Id.* 

§ 18-622(2). The law also requires that "[t]he 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." *Id.* Idaho law defines "[a]bortion" to mean "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." *Id.* § 18-604(1).

The *prima facie* criminal prohibition and license suspension provisions in Idaho's law do not contain any exceptions, including for when the pregnant patient's health or life is endangered. *See id.* § 18-622(2). Thus, the performance of an abortion—even in an emergency, life-saving scenario—would subject a provider to criminal prosecution and require the provider to assert one of the law's "affirmative defense[s]" at trial. *Id.* § 18-622(3). As relevant here, the accused physician would have to prove to a jury, by a preponderance of the evidence, that "[t]he 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," and that 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." *Id.* § 18-622(3)(a)(ii)-(iii).

#### STANDARD OF REVIEW

The United States seeks a preliminary injunction against § 18-622's enforcement as applied to

<sup>&</sup>lt;sup>1</sup> This definition of "abortion" in the Idaho Code is broad and covers some procedures that may not be characterized as an abortion in the medical community, including some circumstances in which a pregnancy is nonviable or termination of pregnancy is necessary to treat a pregnant patient's medical condition. *See* Fleisher Decl. ¶ 32, Ex. A-B. For purposes of this case, the United States uses the term "abortion" as it is defined under the Idaho Code.

EMTALA-mandated care. To obtain such preliminary relief, "a party must show: (1) it will likely succeed on the merits, (2) it will likely suffer irreparable harm in the absence of preliminary relief, (3) the balance of the equities tips in its favor, and (4) the public interest favors an injunction." *AK Futures LLC v. Boyd St. Distro, LLC*, 35 F.4th 682, 688 (9th Cir. 2022) (citation omitted).

#### **ARGUMENT**

# I. The United States is Likely to Succeed in Demonstrating that EMTALA Preempts Idaho's Abortion Law

The United States has a clear likelihood of success on its claim. EMTALA requires hospitals with emergency departments to provide stabilizing treatment for emergency conditions. Physicians treating emergency conditions will sometimes determine that the medically necessary treatment involves or will result in the termination of a pregnancy. Idaho's law conflicts with EMTALA by subjecting physicians to criminal prosecution for terminating *any* pregnancy, irrespective of the medical circumstances. The law also imposes felony criminal liability on physicians who provide abortions, unless the physician is able to prove through an affirmative defense that (as relevant here) the abortion was "necessary to prevent the death of the pregnant woman"—which is far narrower than the standard EMTALA requires for the provision of medically necessary care. Thus, Idaho's abortion law conflicts directly with EMTALA, and is preempted in the context of EMTALA-mandated care.

# A. EMTALA Requires Participating Hospitals to Provide Stabilizing Treatment, Which Includes Abortions for Some Medical Conditions

Under EMTALA, hospitals that receive Medicare funds are generally required (barring an appropriate transfer to another medical facility) to offer and provide "stabilizing treatment" to all patients who arrive at their emergency departments while experiencing an "emergency medical condition." 42 U.S.C. § 1395dd(b)(1). For such patients, hospitals are required to provide "further medical examination and such treatment as may be required to stabilize the medical condition." *Id.* 

§ 1395dd(b)(1)(A); see also 42 C.F.R. § 489.24(a)(1)(i)-(ii).

Congress explicitly contemplated that pregnant patients would be among those arriving at an emergency department experiencing an "emergency medical condition." Id. § 1395dd(e)(1)(A)(i), (B). A number of conditions can arise during, or can be exacerbated by, pregnancy that may constitute "emergency medical conditions." For some patients, a physician will determine that the stabilizing treatment for the patient's emergency condition is termination of the pregnancy. Fleisher Decl. ¶¶ 12-27; Corrigan Decl. ¶¶ 8-30; Cooper Decl. ¶¶ 5-11; Seyb Decl. ¶¶ 6-12. For example, a pregnant patient may arrive at an emergency department with bleeding, pelvic pain, or severe abdominal pain that is being caused by an ectopic pregnancy, a condition in which a nonviable embryo implants outside the uterus, often in a fallopian tube, which can never lead to a live birth. Fleisher Decl. ¶ 13. This is an "emergency medical condition" because it could cause the fallopian tube to rupture, and the patient could bleed to death. Id. In most cases, the physician cannot reasonably know when that rupture will occur—rupture can occur within minutes, hours, or days of an ectopic-pregnancy diagnosis—but without immediate treatment it is reasonably probable that the patient's condition will continue to deteriorate. Id. Given the "serious risk of unknown imminence," and the inevitability that the patient's condition will deteriorate, the "appropriate stabilizing treatment is nearly always" termination of the pregnancy through surgery or medication. Id.

To take another example, a patient may arrive at an emergency room with nausea and shortness of breath, leading to a diagnosis of pre-eclampsia. Fleisher Decl. ¶ 17. Pre-eclampsia can "quickly progress to eclampsia, with the onset of seizures," that can result in a coma, pneumonia, kidney failure, stroke, or cardiac arrest. *Id.* In many cases, pre-eclampsia and eclampsia can be managed with medications that allow the fetus to mature. But in other cases (e.g., situations in which the seizures cannot be controlled), a physician exercising her medical judgment will conclude that termination of the pregnancy is the necessary stabilizing treatment. *Id.* As Dr. Corrigan described, pre-eclampsia for

one patient caused "water on the lungs," which required an immediate termination of the pregnancy. Corrigan Decl. ¶¶ 27-29; Cooper Decl. ¶¶ 6-7 (pre-eclampsia placed patient at risk for stroke, seizure, and pulmonary edema); Seyb Decl. ¶¶ 9-10. A woman may also arrive at the emergency department with an infection after the amniotic sac surrounding the fetus ruptures. Fleisher Decl. ¶ 19. This condition can progress quickly into sepsis, at which point a patient's organs may begin to fail; like the other conditions discussed above, there are some circumstances in which termination of the pregnancy is the medically necessary treatment. *Id*; Corrigan Decl. ¶¶ 11-17; Seyb Decl ¶¶ 7-8.

As a further example, a patient may arrive at the hospital with chest pain or shortness of breath, at which point a doctor discovers longstanding elevated blood pressure or a blood clot. Fleisher Decl. ¶ 15. Pregnancy can substantially exacerbate these conditions, and for some patients with severe symptoms, termination is the necessary treatment under EMTALA because there is a high probability of severe impairment of the lungs, heart, and kidneys without treatment. *Id.* Similarly, a patient may arrive at the hospital with vaginal bleeding caused by a placental abruption. *Id.* ¶ 20; Corrigan Decl. ¶¶ 21-25; Seyb Decl. ¶¶ 11-12. If the bleeding is uncontrollable, a physician may conclude that the stabilizing treatment includes termination of the pregnancy, in order to prevent the patient from going into shock which can result in organ dysfunction such as kidney failure. Fleisher Decl. ¶¶ 20-21.

These are just some of the emergency conditions that can place a pregnant patient's health in serious jeopardy or threaten bodily functions or organs. *Id.* ¶ 22. Despite these conditions' serious risks, it may not be possible for a physician to know whether treatment for any particular condition is "necessary to prevent the death" of the pregnant patient. *Id.* ¶¶ 13-21. Absent the stabilizing treatment EMTALA requires, however, the risk is extremely serious that, for example, a patient with an ectopic pregnancy might bleed to death, an infection could turn into sepsis and cause organ failure, seizures from eclampsia might prove uncontrollable, or a blood clot could lead to kidney failure. *Id.* 

For each of these emergency medical conditions, where a physician determines that abortion

is the stabilizing treatment, EMTALA's plain text requires that treatment be offered and provided upon informed consent. Once a physician identifies that a pregnant individual suffers from an emergency medical condition, that individual must be offered "such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A); see also 42 C.F.R. § 489.24(a)(1)(ii) ("If an emergency medical condition is determined to exist," the hospital must "provide any necessary stabilizing treatment[.]"). The only reasonable interpretation of EMTALA's text is that it requires hospitals to offer stabilizing treatment when medically necessary.

Nothing in EMTALA creates a different rule for circumstances in which the treatment results in termination of a pregnancy. The statute's text does not exempt any particular treatment (abortion or otherwise) from the ambit of stabilizing treatment. *See Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1747 (2020) ("[W]hen Congress chooses not to include any exceptions to a broad rule, courts apply the broad rule."); *In the Matter of Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (finding no "statutory language or legislative history [in EMTALA] evincing a Congressional intent to create an exception to the duty to provide stabilizing treatment"). And any contrary interpretation—*i.e.*, that a hospital need not perform an abortion even when medically necessary to stabilize an emergency medical condition—would undermine EMTALA's overall purpose of ensuring "that patients . . . receive adequate medical emergency care." *Arrington*, 237 F.3d at 1073-74 (citation omitted).

Any argument that EMTALA does not encompass abortions is foreclosed by the specific Affordable Care Act (ACA) provision addressing abortion. *See* 42 U.S.C. § 18023. The ACA allows States to prohibit abortion coverage in certain health plans, *id.* § 18023(a)(1), but the same provision contains a cross-reference to EMTALA and makes explicit that "[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 section 1867 of the Social Security Act (popularly known as 'EMTALA.')" *Id.* § 18023(d). Congress therefore left no doubt that EMTALA encompasses abortion services and

that a State may not override that requirement.

The Weldon Amendment, which is a frequently enacted appropriations provision that prohibits discrimination against certain entities that do not perform abortions, reflects the same understanding. The Weldon Amendment's sponsor, when confronted with a concern that "women will die because they will not have access to an abortion needed to save the life of the mother," expressly referenced EMTALA as addressing that concern: "Hyde-Weldon does nothing of the sort. It ensures that in situations where a mother's life is in danger a health provider must act to save the mother's life. In fact, Congress passed [EMTALA] forbidding critical-care health facilities to abandon patients in medical emergencies, and requires them to provide treatment to stabilize the medical condition of such patients—particularly pregnant women." 151 Cong. Rec. H177 (Jan. 25, 2005) (statement of Rep. Weldon).

More generally, when Congress creates special rules for abortion—or excludes abortion care from otherwise-applicable rules—it does so expressly.<sup>2</sup> "Had Congress likewise intended" to exempt abortions from EMTALA, "it knew how to say so." *Rubin v. Islamic Republic of Iran*, 138 S. Ct. 816, 826 (2018). Indeed, the very same legislation through which Congress considered EMTALA included a separate program that *did* expressly carve out abortion. *Compare* Consolidated Omnibus Reconciliation Act of 1985, H.R. 3128, 99th Cong., 1st Sess., § 124 (language that became EMTALA), *with id.* § 302(b)(2)(B) (expressly excluding abortion from a different program's authorized activities). Courts have also previously understood EMTALA to require abortion-related services. *See, e.g.*, *New York v. U.S. Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019); *Morin v. E. Maine Med.* 

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<sup>&</sup>lt;sup>2</sup> Examples of these abortion-specific provisions include 10 U.S.C. § 1093; 20 U.S.C. § 1688; 22 U.S.C. §§ 5453(b), 7704(e)(4); 25 U.S.C. § 1676; 42 U.S.C. §§ 238n, 280h-5(a)(3)(C), 300a-6, 300a-7, 300a-8, 300z-10, 1397ee(c)(7), 2996f(b)(8), and 12584a(a)(9). Congress has also routinely enacted a similar provision in appropriations laws, commonly referred to as the "Hyde Amendment." *See, e.g.*, Consolidated Appropriations Act, 2022, Div. H, Tit. V, §§ 506, 507, Pub. L. No. 117-103, 136 Stat. 49, 496 (2022); *cf. Harris v. McRae*, 448 U.S. 297, 302 (1980).

Ctr., 780 F. Supp. 2d 84, 96 (D. Me. 2010); California v. United States, No. 05-cv-328, 2008 WL 744840, at \*4 (N.D. Cal. Mar. 18, 2008). Thus, both EMTALA's text and the surrounding statutory scheme confirm that EMTALA includes termination of the pregnancy as a potential stabilizing treatment.

To be sure, EMTALA separately provides that a pregnant person may have an "emergency medical condition" in circumstances in which "the health of [the] . . . unborn child . . . [is] in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). That provision ensures that a hospital's EMTALA obligations extend to a scenario where the "unborn child's" health (and not the pregnant patient's health) is threatened. But nothing in the statutory text indicates that Congress intended to limit the EMTALA-mandated care to pregnant patients, or to require a provider to prioritize the fetus's health over the life or health of the pregnant patient. Instead, when a pregnant patient has an emergency medical condition and a physician concludes that stabilizing treatment would require termination of the pregnancy, EMTALA's text leaves that balancing to the pregnant patient—who may decide, after weighing the risks and benefits, whether to accept or refuse the treatment. See id. § 1395dd(b)(2) (acknowledging that "the individual" with an emergency medical condition, after being informed "of the risks and benefits" of treatment, may "refuse[] to consent to the . . . treatment"). There is therefore no conflict between EMTALA's provision respecting a pregnant patient and an "unborn child."

The statutory context further refutes any alternative interpretation that EMTALA's reference to "unborn child" *forecloses* abortion as a stabilizing treatment. That interpretation would mean that every time a hospital emergency room terminated a pregnancy to save a pregnant patient's life, the hospital committed an EMTALA violation—contrary to the consistent Congressional understanding reflected above. Moreover, that interpretation would mean that Congress, when enacting EMTALA in 1986, intended to prohibit hospitals from performing abortions, but only those abortions involving a threat to the pregnant patient's life or health. "Congress does not hide elephants in mouseholes," *Cyan, Inc. v. Beaver County Employees Ret. Fund*, 138 S. Ct. 1061, 1071-72 (2018), and the notion that

Congress intended EMTALA to forbid necessary medical care is fundamentally at odds with the statute's aim of guaranteeing—not prohibiting—emergency medical care. *See, e.g.*, 131 Cong. Rec. S13892 ("We cannot stand idly by and watch those Americans who lack the resources be shunted away from immediate and appropriate emergency care whenever and wherever it is needed.") (statement of Sen. Durenberger). In sum, Idaho cannot meaningfully dispute that EMTALA's requirement to offer stabilizing treatment includes abortion when a provider determines that treatment is medically necessary.

### B. Idaho's Near-Absolute Abortion Ban Conflicts with EMTALA

Because Idaho's law makes it a crime to perform an abortion even when a physician concludes that such a procedure is the necessary stabilizing treatment under EMTALA, Idaho's law is preempted.

As EMTALA provides, "any State or local law requirement" is preempted "to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). This preemption provision encompasses both impossibility and obstacle preemption. *Draper*, 9 F.3d at 1393. Applying these principles to a state law that entitled physicians to forgo medical treatment that EMTALA would otherwise require, the Fourth Circuit found the analysis to be straightforward: "[T]o the extent that [the state law] exempts treating physicians in participating hospitals from providing care [under specified circumstances], it is preempted—it does not allow the physicians . . . to refuse to provide her with [stabilizing treatment]." *Matter of Baby K*, 16 F.3d at 597. Numerous courts have likewise found state laws preempted when they stood as obstacles to EMTALA's civil liability provisions. *See Root v. New Liberty Hosp. Dist.*, 209 F.3d 1068, 1070 (8th Cir. 2000) (Missouri state law preempted to the extent it sought to shield its state-operated hospitals from EMTALA liability); *Burditt v. HHS*, 934 F.2d 1362, 1373-74 (5th Cir. 1991) (physician could not avoid EMTALA liability by relying on state law contract principles, because "[w]e recognize no reason for conditioning the applicability of EMTALA's civil penalty provision on the vagaries of the several state laws"); *see also*,

e.g., Cox v. Cabell Huntington Hosp., Inc., 863 F. Supp. 2d 568, 572 (S.D. W. Va. 2012); Merce v. Greenwood, 348 F. Supp. 2d 1271, 1277 (D. Utah 2004). Consistent with these decisions, Idaho's abortion law conflicts with EMTALA, and therefore is preempted, for three independent reasons.

First, Idaho law flatly prohibits—and attaches criminal penalties and loss of license to medical care that EMTALA requires. It is thus impossible for Idaho medical providers to comply with both Idaho and federal law. The Idaho law establishes an affirmative defense for abortions "necessary to prevent the death of the pregnant woman," Idaho Code § 18-622(3)(a)(ii), but EMTALA requires necessary stabilizing treatment for any "emergency medical condition," which is broader than just those treatments necessary to prevent death. See 42 U.S.C. § 1395dd(e)(1)(A) (defining "emergency medical condition" to include conditions that "plac[e] the health of the individual . . . in serious jeopardy," threaten "serious impairment to bodily functions," or risk "serious dysfunction of any bodily organ or part"). Serious medical conditions exist that meet EMTALA's criteria but for which an abortion might not be necessary to prevent death. See Part I.A, supra; Fleisher Decl. ¶¶ 12-27. Because Idaho law criminalizes terminating a pregnancy in these circumstances, but federal law requires physicians to offer and provide such stabilizing treatment when medically necessary, it is impossible for physicians to comply with both laws; the Idaho law is therefore preempted. See, e.g., Chamber of Com. of U.S. v. Bonta, 13 F.4th 766, 781 (9th Cir. 2021) ("An arbitration agreement cannot simultaneously be 'valid' under federal law and grounds for a criminal conviction under state law"); Valle del Sol Inc. v. Whiting, 732 F.3d 1006, 1028 (9th Cir. 2013) (state law was preempted because it allowed "individuals [to] be prosecuted for conduct that Congress specifically sought to protect").

Second, even in circumstances for which Idaho offers an affirmative defense—where the procedure is "necessary to prevent the death of the pregnant woman," Idaho Code § 18-622(3)(a)(ii)—the affirmative defense structure *itself* "is an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Draper*, 9 F.3d at 1394. The Idaho law allows physicians to be

prosecuted for performing any abortion, regardless of circumstances. Even where the affirmative defense would be satisfied, the Idaho law would still allow for indictment, arrest, and criminal prosecution of physicians each and every time a pregnancy is terminated—including when the physician determined that the procedure was necessary stabilizing treatment under EMTALA. Relegating any exception from criminal liability to an affirmative defense itself poses an obstacle to EMTALA's "overarching purpose of ensuring that patients . . . receive adequate emergency medical care," Vargas By & Through Gallardo v. Del Puerto Hosp., 98 F.3d 1202, 1205 (9th Cir. 1996), because exposure to criminal prosecution will render physicians less inclined or entirely unwilling to risk providing treatment. See Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 350-51 (2001) (holding that fear of being "expose[d] . . . to unpredictable civil liability" under state law, for conduct condoned by federal law, was sufficient for preemption); Arizona v. United States, 567 U.S. 387, 408 (2012) (preempting a state law authorizing the arrest of aliens, because "[t]he result could be unnecessary harassment of some aliens . . . who federal officials determine should not be removed").

Third, the Idaho law conflicts with EMTALA by threatening the licenses of medical professionals who perform or assist in providing an abortion. Fleisher Decl. ¶ 27; Corrigan Decl. ¶ 32-34; Cooper Decl. ¶ 12; Seyb Decl. ¶ 13-14. Specifically, beyond the physician who performs the abortion, see Idaho Code § 18-604(12), the Idaho law mandates that any "health care professional . . . 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." Id. § 18-622(2). This provision could apply to a number of personnel involved in emergency care, including nurses, pharmacists, physicians' assistants, and anesthesiologists. Cf. id. §§ 54-1401 (nursing licensure), 54-1718 (pharmacists), 54-1810 (physicians), 54-1810 (physicians' assistants).

Notably, these professionals' licenses can be revoked even for someone else's conduct,

because in any "disciplinary action by an applicable licensing authority," they must likewise prove the elements of the affirmative defense: that the physician appropriately determined the necessity of the abortion and the appropriate manner to perform it. *See* Idaho Code § 18-622(3)(a)(ii)-(iii). The obvious effect will be to discourage medical professionals from participating in *any* abortions. Even if a doctor *tells* a nurse, for example, that an abortion is necessary to prevent death or serious bodily harm, the nurse could still be subject to disciplinary action for assisting in the abortion, and potentially have their license revoked based on the disciplinary board's determination that the *doctor* erred in making a "good faith medical judgment" about how to treat the pregnant patient. *Id.* Thus, the Idaho law penalizes and deters medical professionals from participating in medically necessary abortions, contrary to EMTALA's "overarching purpose of ensuring that patients . . . receive adequate emergency medical care," *Vargas*, 98 F.3d at 1205.

For each of these reasons, § 18-622 conflicts directly with EMTALA, and the United States has demonstrated a likelihood of success on its preemption claim. Section 18-622 is therefore preempted to the extent it allows Idaho to initiate criminal prosecutions against, attempt to revoke the license of, or seek to impose any other form of liability on, medical providers with respect to EMTALA-covered care.

### II. The Equitable Balance Supports Entry of a Preliminary Injunction

The remaining factors all support entry of a preliminary injunction, because allowing the Idaho law to take effect would result in irreparable harm to the public and to the United States' sovereign interests. *Cf. Nken v. Holder*, 556 U.S. 418, 435 (2009) (noting that, in suits involving the United States, the balance of equities and "public interest . . . factors merge").

First and most fundamentally, allowing the Idaho law to go into effect would threaten severe harm to pregnant patients in Idaho, who would no longer be guaranteed the critical emergency care to which they are entitled under federal law. *See Valle del Sol*, 732 F.3d at 1029 ("It is clear that it would

not be equitable or in the public's interest to allow the state to violate the requirements of federal law, especially when there are no adequate remedies available." (modifications omitted)). As discussed above, numerous pregnancy-related conditions could require emergency care including abortion, and these conditions have occurred and will inevitably occur again within Idaho. Corrigan Decl. ¶¶ 8, 15, 23, 29; Cooper Decl. ¶¶ 5, 6, 8, 10, 12; Seyb Decl. ¶¶ 6, 7, 9, 11, 13. To take just one example, in Idaho, Medicaid has covered treatment for approximately 100 ectopic pregnancies each year. Fleisher Decl. ¶ 36. Medical literature also confirms that other diagnoses qualifying as "emergency medical conditions" for pregnant individuals also occur frequently. *Id.* ¶¶ 28-38. And Idaho-based physicians have personally treated patients with these types of conditions. Corrigan Decl. ¶ 8 (anticipating that "the number will increase"); Seyb Decl. ¶ 6 (treating "a dozen" per year); Cooper Decl. ¶ 5.

Given that Idaho has approximately 22,000 births per year,<sup>3</sup> and a large number of high-risk pregnancies due to surrogacy, it is virtually guaranteed that these emergency medical conditions will occur for a sizeable number of pregnant patients within Idaho. Corrigan Decl. ¶¶ 8, 19; Fleisher Decl. ¶¶ 36-38. Allowing the law to go fully into effect would discourage physicians from providing necessary care in emergency circumstances, resulting in significant and irreparable harm to numerous pregnant patients within Idaho. Every day that the law is in effect, there is a likelihood that some pregnant persons suffering medical emergencies will face irreversible health consequences, such as strokes and organ failure, and some are likely to die. *See* Fleisher Decl. ¶¶ 36-38; Corrigan Decl. ¶¶ 8, 17, 23-24, 29; Cooper Decl. ¶ 6, 8, 10, 12; Seyb Decl. ¶ 7, 9, 11, 13; *see also Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004) (irreparable harm "includes delayed and/or complete lack of necessary treatment, and increased pain and medical complications"); *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) ("Plaintiffs have shown a risk of irreparable injury, since enforcement of the California rule may deny

<sup>&</sup>lt;sup>3</sup> Idaho Dep't of Health & Welfare, 2010-2020 Idaho Resident Births, VS Natality – Data Results, 2010-2020, https://www.gethealthy.dhw.idaho.gov/idaho-births-vital-statistics (attached as Ex. G-C).

them needed medical care.").

Indeed, patients in Idaho are already facing dire situations. Dr. Corrigan treated a patient who, after initially being denied care, arrived at the hospital two weeks later with an infection in her uterus, at risk of sepsis, and termination was necessary to preserve her life. Corrigan Decl. ¶¶ 12-15. And Dr. Seyb recently received a call from a physician whose patient was "clear[ly]" "in danger" due to severe bleeding, but the physician feared the ramifications of providing medically necessary care. Seyb. Decl. ¶¶ 13. Had § 18-622 been in effect, the life-saving treatment these patients received could have been further delayed or denied. Corrigan Decl. ¶¶ 31-35; Cooper Decl. ¶¶ 12; Seyb Decl. ¶¶ 13-14.

Moreover, Idaho's law also interferes with the United States' sovereign interest in ensuring the proper administration of federal law and the Medicare program. See, e.g., United States v. Alabama, 691 F.3d 1269, 1301 (11th Cir. 2012) ("The United States suffers injury when its valid laws in a domain of federal authority are undermined by impermissible state regulations."); cf. Vt. Agency of Nat. Res. v. U.S. ex rel. Stevens, 529 U.S. 765, 771 (2000). The United States has agreed to provide federal Medicare funds to hospitals in Idaho, in return for those hospitals promising (among other things) to comply with EMTALA for all patients, not just for Medicare beneficiaries. See 42 U.S.C. § 1395cc(a)(1)(I). But the Idaho law seeks to disrupt the program and deprive the United States of the benefit of its bargain by prohibiting Idaho hospitals from performing EMTALA-mandated services, notwithstanding that hospitals' receipt of Medicare funds is conditioned on them doing so. Thus, the Idaho law threatens "harm to the administration and integrity of Medicare," United States v. Mackby, 339 F.3d 1013, 1018 (9th Cir. 2003), because payments to hospitals will no longer guarantee the availability of services that Congress mandated. Wright Decl. ¶¶ 14, 16. This harm is substantial: the United States provided over \$3 billion in Medicare funding to hospitals within Idaho over fiscal years 2018-2020, with approximately \$74 million attributable to emergency departments. Shadle Decl. ¶¶ 6-8.

The Idaho law also interferes with the written agreements that the United States has entered

into with hospitals pursuant to Medicare. These Spending Clause agreements likewise require hospitals to comply with EMTALA. *See* Background, Part I.C, *supra*. It is well-settled that third parties may not interfere with the terms of Spending Clause legislation, *see Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 270 (1985), but here, the State of Idaho is directly interfering with the agreements between the United States and the 52 hospitals within Idaho that are receiving Medicare funds. Thus, irreparable harm exists on this basis as well.

Finally, on the other side of the ledger, the State of Idaho will suffer no cognizable harm as a result of the requested preliminary relief. Idaho's abortion law is not currently in effect, has never been in effect, and therefore enjoining it from going into effect, as applied to EMTALA-mandated care, would simply preserve the status quo during the short period necessary for further litigation. *See All. for Wild Rockies v. Pierson*, 550 F. Supp. 3d 894, 898 (D. Idaho 2021) ("The purpose of a preliminary injunction is to preserve the status quo and prevent the 'irreparable loss of rights' before a final judgment on the merits[.]"). Given the significant harms that would result if the Idaho law were to go into effect to prohibit EMTALA-mandated care—both for pregnant individuals as well as the United States' sovereign interests—and the corresponding lack of harm to the State of Idaho from a temporary injunction against certain applications of its law, the equitable factors plainly favor entry of preliminary relief against the Idaho law's enforcement.

#### **CONCLUSION**

For the foregoing reasons, the Court should enter a preliminary injunction prohibiting the State of Idaho—including all of its officers, employees, and agents—from enforcing Idaho Code § 18-622(2)-(3) as applied to EMTALA-mandated care.

Dated: August 8, 2022

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### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

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

v.

THE STATE OF IDAHO,

Defendant.

### [PROPOSED] ORDER

Upon consideration of the United States' Motion for a Preliminary Injunction, and the parties' respective submissions in support thereof and in opposition thereto, the Court hereby ORDERS that the United States' motion is GRANTED.

It is FURTHER ORDERED that the State of Idaho, including all of its officers, employees, and agents, are preliminarily enjoined from enforcing Idaho Code § 18-622(2)-(3) as applied to medical care required by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd.

It is FURTHER ORDERED that the State of Idaho, including all of its officers, employees, and agents, are specifically prohibited from initiating any criminal prosecution against, attempting to suspend or revoke the professional license of, or seeking to impose any other form of liability on, any medical provider or hospital based on their performance of conduct that is defined as an "abortion" under Idaho Code § 18-604(1), but that is necessary to avoid: (i) "placing the health of" a pregnant patient "in serious jeopardy"; (ii) a "serious impairment to bodily functions" of the pregnant patient; or (iii) a "serious dysfunction of any bodily organ or part" of the pregnant patient, pursuant to 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii).

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Submitted by: Lisa Newman Counsel for the United States

# EXHIBIT A

## UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

V

THE STATE OF IDAHO,

Defendant.

### DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties.

- 1. I am employed by the United States Department of Health and Human Services (HHS) in CMS. I am the Chief Medical Officer and Director of the Center for Clinical Standards and Quality for CMS. In this capacity, I am responsible for executing all national clinical, quality, and safety standards for all Medicare and Medicaid-certified healthcare facilities and providers, as well as establishing coverage determinations for items and services that improve health outcomes for Medicare beneficiaries.
- 2. I am also currently a Professor Emeritus of Anesthesiology and Critical Care at the University of Pennsylvania Perelman School of Medicine and continue to provide anesthesia care approximately three times per month at the Hospital of the University of Pennsylvania. From 2004 until 2020, I was the Robert D. Dripps Professor and Chair of Anesthesiology and Critical Care

and Professor of Medicine at the University of Pennsylvania and Chair of the Department of Anesthesiology and Critical at the Hospital of the University of Pennsylvania (HUP) and Penn Presbyterian Medical Center. Prior to joining the University of Pennsylvania, I was an attending anesthesiologist at The Johns Hopkins Hospital (JHH) from 1992-2003, where I provided obstetrical anesthesia and anesthesia for emergency surgical procedures. While at JHH, I was appointed in 1999 as the Clinical Director of Operating Rooms, a position I held until I moved to the University of Pennsylvania in 2004.

- 3. In addition, I have held a number of other faculty, hospital, and administrative appointments, which are set forth in my curriculum vitae, which is attached hereto as Ex. A. Among other appointments listed on my CV, since 2007 I have served as an elected member of the National Academy of Medicine (NAM) (formerly Institute of Medicine), and between 2016 and 2018. I served as a member of NAM's Committee on Reproductive Health Services for Assessing the Safety and Quality of Abortion Care, and was an author of the 2018 report on The Abortion Care in the United States. Safety Quality of and https://www.ncbi.nlm.nih.gov/books/NBK507236/. My work with this committee on safety of abortion services was focused on risks to women both from the abortion procedure itself and from delays in obtaining abortion procedures. I was also the President of the Medical Board of HUP from 2014-16 and a member of the Board of Trustees of HUP from 2012-16, in which capacity I oversaw the review and approval of hospital policies and procedures including those pursuant to EMTALA. Additionally, I was Chair of the Credentials Committee of HUP from 2008-14, in which capacity I oversaw the evaluation and credentialing of all medical providers on the staff.
- 4. I graduated with a B.A. from the University of Pennsylvania in Molecular Biology in 1981. I earned an M.D. from the State University of New York at Stony Brook in 1986. I

completed an internship in surgery at the University of Minnesota from 1986 to 1987, and a residency in anesthesiology at Yale University from 1987 to 1990.

- 5. In my thirty-plus years as a medical doctor, I have had extensive experience providing anesthesia for obstetrical care, including through the provision of anesthesia for the treatment of pregnancy-related conditions that threaten the life and/or health of pregnant patients as well as review of complications of care in my role as Chair of the Department. For example, in my practice at JHH from 1992-2003, I provided emergency obstetrical care approximately 3 times per month. In my role as Clinical Director of the Operating Rooms at JHH, I evaluated and determined the urgency of proceeding to surgery for all emergency surgical cases, including ectopic pregnancies, and provided anesthetic care for many pregnant individuals requiring emergent care including vaginal bleeding and preeclampia/eclampsia.
- 6. In addition, through my official duties at CMS, I am familiar with federal Medicare and Medicaid requirements, as well as data and other information collected by CMS and HHS regarding medical risks related to pregnancy. And based on my role at CMS, my roles as a medical practitioner, and my leadership roles in several hospitals and medical organizations, I am experienced with the requirements of the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, including how they arise in the actual practice of medicine.

## **IDAHO LAW AND EMTALA**

7. I understand that, if the Idaho law goes into effect on August 25, 2022, "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion" and that the crime of criminal abortion is a felony that is punishable by up to five years in prison and loss of medical license. Idaho Code § 18-622(2). I further understand that Idaho law defines "abortion" as "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." Idaho Code § 18-622. This definition of "abortion" in the Idaho Code covers some procedures that would not be characterized as an abortion in the medical community. In some circumstances in which a pregnancy is nonviable and/or termination of pregnancy is necessary to treat a pregnant patient's medical condition, physicians may not consider that treatment to be properly characterized as an abortion.

- 8. I further understand that Idaho law includes an "affirmative defense" allowing physicians to avoid criminal liability only if they can prove, among other things, that an abortion was "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(ii).
- 9. In addition, I am aware of EMTALA's requirements for hospitals participating in Medicare. In particular, EMTALA requires that "[i]f any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—(A) with 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 certain requirements in subsection (c) of the statute. 42 U.S.C. § 1395dd. A hospital may not discharge or otherwise transfer a person with a medical condition who has not been stabilized unless the individual requests a transfer or a physician certifies that the benefits of a transfer to another medical facility outweighs the increased risks to the patient. 42 U.S.C. § 1395dd(c).
- 10. I am aware that EMTALA defines "emergency medical condition" as: "(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." 42 U.S.C. § 1395dd(1).

11. I am aware that EMTALA defines "to stabilize" to mean "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).

### EMERGENCY MEDICAL CONDITIONS IMPLICATED BY IDAHO LAW

at CMS, I know that pregnant patients experience a number of medical conditions that fall within the definition of "emergency medical condition" set forth in EMTALA. This is because for these medical conditions, "in the absence of immediate medical attention," which can include monitoring, treatment, or both, the condition "could reasonably be expected to result in" the patient's health being "plac[ed] . . . in serious jeopardy," "serious impairment to [the patient's] bodily functions," or "serious dysfunction of any bodily organ or part [of the patient]," as described more fully below. I also know that the appropriate stabilizing treatment that is necessary to avoid "serious jeopardy," "serious impairment," and "serious dysfunction," which would otherwise result from those conditions, is very frequently—and in some cases nearly always—a form of treatment that is covered by the definition of "abortion" set forth in the Idaho Code. EMTALA requires providing such care independent of whether doing so is, or well before doing so becomes, necessary to prevent the patient's death. As explained further below, in some cases where the

patient's health is unambiguously threatened, it may be less clear whether there is also a certainty of death without stabilizing treatment—and a physician may not ever be able to confirm whether death would result absent immediate treatment. EMTALA does not allow leaving the patient untreated when doing so would irreparably risk or harm their health, as with the conditions discussed below.

13. For example, a pregnant individual may present to an emergency department with bleeding, pelvic pain or severe abdominal pain that, when evaluated, is determined to be caused by an ectopic pregnancy. An ectopic pregnancy is when an embryo or fetus grows outside of the uterus, frequently in a fallopian tube. An ectopic pregnancy in a fallopian tube is an emergency medical condition that places the patient's life in jeopardy because it will cause the fallopian tube to rupture and in the vast majority of cases cause significant and potentially fatal internal bleeding. In most cases, the physician cannot reasonably know when that rupture will occur—it could happen within minutes, hours or days of the physician's examination—but without immediate treatment it is reasonably probable that the patient's condition will continue to deteriorate. Accordingly, given this serious risk of unknown imminence, where a patient suffers from an ectopic pregnancy, especially in a fallopian tube, the appropriate stabilizing treatment is nearly always emergency surgery and removal of the involved fallopian tube, including the embryo or fetus, or administration of a drug to cause embryonic or fetal demise. One of these two treatments is necessary because of the inevitability that the fallopian tube will rupture absent surgery or intervention with medication that causes embryonic or fetal demise. There is an extremely high risk that such rupture would result in the patient bleeding to death. Because a physician can determine with reasonable certainty that an ectopic pregnancy exists and that, depending upon the location, a rupture will occur as a result, but the physician cannot discern with reasonable certainty

the time at which that rupture will occur, it is necessary that an ectopic pregnancy be treated immediately or else the patient's life and health will likely continue to deteriorate and remain at constant and ongoing risk.

- 14. Even though a physician at a hospital where EMTALA applies could conclude that this treatment is required for an ectopic pregnancy, particularly one involving a fallopian tube, Idaho law prohibits this treatment. Idaho's definition of abortion would include both the medical and surgical treatment described in ¶ 13, because both cause embryonic or fetal demise in a clinically diagnosable pregnancy. This treatment would be prohibited by Idaho law even though an ectopic pregnancy has no chance of maturing into a viable child. Additionally, despite the extremely serious risks posed by an ectopic pregnancy, particularly in a fallopian tube, and the inevitability of a rupture, which are apparent at the time when treatment is required to address those risks, a physician may not be able to establish or know, with certainty, that termination of the pregnancy is "necessary to prevent the death of the woman." However, that does not change the fact that the patient's condition will very likely deteriorate without the necessary treatment, and that failure to provide the necessary treatment will seriously jeopardize the patient's health and/or life in the process.
- 15. As another example, a pregnant individual may present to the emergency room with chest pain and severe shortness of breath, requiring supplemental oxygen to keep their blood oxygen levels in reasonable range. The patient may be early in or mid-pregnancy and during the evaluation may be diagnosed with severe heart failure related to long-standing pulmonary hypertension (i.e., elevated blood pressure in the vessels to the lungs), or a massive pulmonary embolism (i.e., a blood clot to the lungs). For some patients, pregnancy can substantially exacerbate the heart failure and initially cause the patient to have difficulty breathing at rest that

can then turn into further complications from a lack of oxygen as well as a drop in blood pressure. Some pregnant patients may present to the emergency room when they are in extremis, and a physician will need to place the patient on a ventilator and prescribe medications to maintain the blood pressure. Severe heart failure, especially from pulmonary hypertension or a pulmonary embolism, can be an emergency medical condition because if left untreated, the patient's condition will continue to deteriorate and cardiac arrest or inability to oxygenate the patient could result, which places the patient's life, health, and bodily organs in jeopardy. In some circumstances, the appropriate stabilizing treatment for a patient suffering from severe heart failure is treatment of the heart and blood vessels through medications. In severe cases, the physician may determine that, despite other medical treatment, the patient continues to have worsening deterioration of blood oxygenation and maintenance of blood pressure. In such circumstances, the physician could conclude that termination of the pregnancy is medically necessary because, by virtue of the severity of the symptoms, there is a high probability of the pregnant patient's death or impairment or severe dysfunction of bodily organs (such as the lungs, heart, and kidneys) absent that termination.

16. Even though a physician at a hospital where EMTALA applies could conclude that this treatment is required for severe heart failure, Idaho law prohibits this treatment because it would cause embryonic or fetal demise. This treatment would be prohibited by Idaho law even though the pregnant individual with this condition would most likely not survive to carry the pregnancy materially further. Additionally, despite the extremely serious risks posed by severe heart failure, which are apparent at the time when treatment is required to address those risks, a physician may not be able to establish or know, with certainty, that termination of pregnancy is "necessary to prevent the death of the woman." However, that does not change the fact that the

patient's condition will very likely deteriorate without the necessary treatment, and that failure to provide the necessary treatment will seriously jeopardize the patient's health and/or life in the process.

17. As a third example, a pregnant individual may present to the emergency department with nausea and shortness of breath, which an initial evaluation may diagnose as resulting from new onset of high blood pressure. Pre-eclampsia is when high blood pressure and high levels of protein in the urine develop in a pregnant individual, usually midway through the pregnancy. Preeclampsia can quickly progress to eclampsia with the onset of seizures, and a physician cannot discern when that progression to seizures will occur with reasonable medical certainty in all cases, especially when the blood pressure cannot be controlled. Pre-eclampsia and eclampsia are emergency medical conditions because they place the patient's life in jeopardy or can cause serious impairment to bodily functions. Without treatment for severe pre-eclampsia/eclampsia, the patient's condition is reasonably likely (indeed nearly certain) to deteriorate. Specifically, the seizures that characterize the transition from pre-eclampsia to eclampsia can cause coma, pneumonia from the aspiration of stomach contents, kidney failure, stroke and even cardiac arrest. While the only curative treatment for pre-eclampsia or eclampsia is delivery of the fetus, in most and many cases, the pregnant patient with pre-eclampsia will respond reasonably promptly to medications to control their blood pressure, reduce their chances of seizures, and mature the fetus' lungs to allow delivery as soon as possible. However, in some cases in which high blood pressure and/or the seizures of severe pre-eclampsia/eclampsia cannot be controlled, termination of the pregnancy is medically necessary. In such cases, absent termination of the pregnancy, death or severe bodily dysfunction of the pregnant patient is the reasonably probable outcome.

- 18. Even though a physician at a hospital where EMTALA applies could conclude that this treatment is required for severe pre-eclampsia or eclampsia, Idaho law prohibits this treatment because the treatment would cause fetal demise. This treatment would be prohibited by Idaho law even though the pregnant individual with this condition would most likely not survive to carry the pregnancy materially further. Additionally, despite the extremely serious risks posed by this severe preeclampsia/eclampsia, which are apparent at the time when treatment is required to address those risks, a physician may not be able to establish or know, with certainty, that termination of pregnancy is "necessary to prevent the death of the woman." However, that does not change the fact that the patient's condition will deteriorate without the necessary treatment, and that failure to provide the necessary treatment will seriously jeopardize the patient's health and/or life in the process.
- department with a life-threatening infection of the uterine contents. Such an infection may occur when there is premature rupture of the membranes (PROM), which is when the amniotic sac surrounding the embryo or fetus ruptures and the uterus or embryo/fetus can become infected. The infection can progress to sepsis wherein multiple body organs and functions can start failing including the heart, lungs and blood pressure, which could lead to death. Sepsis can progress quickly, and a physician cannot discern with reasonable medical certainty if or when the sepsis will resolve or result in organ failure or death without immediate treatment. Septic infection is an emergency medical condition because it places the patient's life and health in jeopardy or can cause serious impairment to bodily functions; if untreated, it can lead to kidney failure and even cardiac arrest. In many cases, the pregnant patient can respond to treatment with antibiotics and concurrently be administered medications to support their blood pressure. However, if the

and in circumstances in which the embryo or fetus is infected and is causing the sepsis, that necessary treatment could include removal of the embryo or fetus, which may result in embryonic or fetal demise. Absent this treatment for severe sepsis unresponsive to antibiotics and blood pressure support, the patient's condition will deteriorate, and death or severe bodily dysfunction of the pregnant patient is the reasonably probable outcome.

- 20. Even though a physician at a hospital where EMTALA applies could conclude that this treatment is required for severe sepsis, Idaho law prohibits this treatment because the treatment would cause embryonic or fetal demise. This treatment would be prohibited by Idaho law even though the pregnant individual with this condition would most likely not survive to carry the pregnancy materially further. Additionally, despite the extremely serious risks posed by severe sepsis, which are apparent at the time when treatment is required to address those risks, a physician may not be able to establish or know, with certainty, that termination of pregnancy is "necessary to prevent the death of the woman." However, that does not change the fact that the patient's condition will deteriorate without the necessary treatment, and that failure to provide the necessary treatment will seriously jeopardize the patient's health and/or life in the process.
- 21. As a fifth example, a pregnant individual may present to the emergency department with vaginal bleeding. Vaginal bleeding may occur in some of the previously described conditions, but it can also be a result of a placental abruption, which occurs when the placenta partly or completely separates from the inner wall of the uterus. Placental abruption with uncontrolled and catastrophic bleeding is an emergency medical condition that places the patient's life in jeopardy or can cause serious impairment to bodily functions. This is because catastrophic and/or uncontrolled bleeding can lead to shock, which can result in organ dysfunction such as kidney

failure, and even cardiac arrest. The placental abruption can be diagnosed in the emergency department by examination, including ultrasound, to check the location of the bleeding. If bleeding will not stop, then a physician could conclude that the necessary stabilizing treatment for the uncontrolled and catastrophic bleeding includes removal of the fetus or the entire uterus (*i.e.* a hysterectomy, which also results in termination of the pregnancy), which could result in fetal demise. Absent this treatment for placental abruption where indicated, the patient's condition will deteriorate and death or severe bodily dysfunction of the pregnant patient is the reasonably probable outcome.

- 22. Even though a physician at a hospital where EMTALA applies could conclude that this treatment is required for placental abruption, Idaho law prohibits this treatment because termination would cause fetal demise. This treatment would be prohibited by Idaho law even though the pregnant individual with a placental abruption would most likely not survive to carry the pregnancy materially further. Additionally, despite the extremely serious risks posed by placental abruption with catastrophic or uncontrolled bleeding, which are apparent at the time when treatment is required to address those risks, a physician may not be able to establish or know, with certainty, that termination of pregnancy is "necessary to prevent the death of the woman." However, that does not change the fact that the patient's condition will deteriorate without the necessary treatment, and that failure to provide the necessary treatment will seriously jeopardize the patient's health and/or life in the process.
- 23. The emergency medical conditions described in paragraphs 13-22 above are just some examples of those that present in pregnant patients, as to which the treating physician could, in the exercise of their professional medical judgment, determine that the stabilizing treatment would include termination of pregnancy. Myriad other medical conditions that present in pregnant

patients may cause acute symptoms that place the health of the pregnant patient in serious jeopardy, or else risk serious impairment to the pregnant patient's bodily functions or dysfunction of a bodily organ or part. How emergency conditions present in a pregnant patient will often vary depending on the patient's specific circumstances, and termination of pregnancy may be a necessary treatment to stabilize the patient based on their physical circumstances.

- 24. For each of the medical conditions described above (as well as other emergency medical conditions that present in pregnant patients), in some cases, termination of pregnancy would be the only option to ensure that a pregnant patient will not die, or suffer a serious impairment to their bodily functions, or serious dysfunction of any bodily organ or part as a result of their emergency medical condition. In that regard, a physician could conclude that termination of the pregnancy is the only way to stabilize the pregnant patient as required by EMTALA.
- 25. In other words, pregnancy termination may be necessary to ensure that "no material deterioration of the patient's condition is likely to result from or occur during the transfer [including discharge] from a facility," as is required by EMTALA. 42 U.S.C. § 1395dd(e)(3). Yet, under the Idaho abortion ban, physicians at hospital emergency rooms could be prosecuted for administering necessary stabilizing treatment to patients with these conditions despite knowing that the patients will suffer severe bodily impairment or serious jeopardy to their health without such treatment.
- 26. Indeed, under the definition of "criminal abortion" in the Idaho law, this is true even in cases in which the physician knows that there is no chance that the pregnancy will result in a live birth. Because the Idaho law prohibits termination of any pregnancy that would "cause the death of the unborn child," a physician would be forbidden from administering treatment even if: (1) a patient presents with an emergency medical condition; (2) which will render it impossible

for the pregnancy to result in a live birth; but (3) embryonic or fetal demise has not yet occurred at the time the patient arrives at the hospital. Under those circumstances, a physician following Idaho law would be required to wait for embryonic or fetal demise before stabilizing the pregnant patient, causing the pregnant patient to suffer through the emergency medical condition, often with great pain and increased risk to their health and/or life.

27. When stabilizing treatment is provided at a hospital that includes termination of the pregnancy (including "abortion" as defined under Idaho law), that procedure may require the participation of numerous personnel—not just the physician performing the procedure, but also frequently nurses, operating room technicians, anesthesiologists or certified registered nurse anesthetists, pharmacists, physician's assistants, or other medical health professionals.

### PREVALENCE OF EMERGENCY PREGNANCY CONDITIONS

- 28. Based on my role at CMS and my experience in public health, I am aware of statistics regarding the prevalence of emergency pregnancy conditions, and I am experienced in identifying reliable data about those conditions. Data relating to health risks associated with pregnancy confirms that a significant percentage of pregnant patients experience emergency health conditions, including conditions as to which termination of pregnancy is the appropriate stabilizing treatment.
- 29. According to the Centers for Disease Control and Prevention (CDC), the overall maternal mortality rate in the United States in 2020 was 23.8 maternal deaths per 100,000 live births. *See* Donna L. Hoyert, CDC, *Maternal Mortality Rates in the United States*, 2020 (Feb. 23, 2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm. That represents an increase from 17.4 and 20.1 maternal deaths per 100,000 live births

in 2018 and 2019, respectively. *See id.* The maternal mortality rates for Black women are significantly higher and have similarly increased between 2018 and 2020. *See id.* 

- 30. According to CDC, for each maternal death, more than 50 pregnant women suffer significant short- or long-term consequences to their health. See CDC, Severe Maternal Morbidity:

  \*Rate per 10,000 Delivery Hospitalizations\*\* (Feb. 10, 2020), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm. These consequences include heart attacks, sepsis, eclampsia, and kidney failure. \*Id.\*\*
- 31. Pregnant patients regularly come to hospitals with emergency medical conditions, including the conditions discussed above.
- 32. I am aware that the American College of Obstetricians and Gynecologists (ACOG) has reported, for instance, that ectopic pregnancies account for approximately two percent of all pregnancies, though the incidence could be significantly higher given the lack of recent national surveillance data. *See* ACOG Practice Bulletin No. 193 (Mar. 2018) (attached as Exhibit B). I am also aware that data from 2011 to 2013 shows that ruptured ectopic pregnancies account for 2.7 percent of all pregnancy-related deaths and are the leading cause of hemorrhage-related maternal deaths. *See id*.
- 33. I am also aware that CDC estimates that pre-eclampsia happens in 1 in 25 pregnancies. See CDC, High Blood Pressure During Pregnancy (May 6, 2021), https://www.cdc.gov/bloodpressure/pregnancy.htm I am further aware that ACOG has reported that the rate of pre-eclampsia in the United States increased by 25 percent between 1987 and 2004. See ACOG Practice Bulletin No. 222 (June 2020) (attached as Exhibit C).
- 34. I am also aware that ACOG has reported that cardiovascular disease—including as a result of hypertension—affects approximately one to four percent of pregnancies in the United

States per year and that cardiovascular disease accounts for 26.5 percent of pregnancy-related deaths in the United States. *See* ACOG Practice Bulletin No. 212 (May 2019) (attached as Exhibit D). ACOG additionally reports that hypertensive disorders affect up to ten percent of pregnancies and that, in those affected pregnancies, pregnant persons are eight to thirteen times more likely to suffer a myocardial infarction (heart attack).

- 35. Further, I am aware that ACOG has reported that premature rupture of membranes (PROM) complicates two to three percent of pregnancies in the United States. *See* ACOG Practice Bulletin No. 217 (Mar. 2020) (attached as Exhibit E). ACOG has also reported that intraamniotic infection occurs in 15 to 25 percent of preterm PROM cases and postpartum infection occurs in 15 to 25 percent of cases, with the risk higher in cases involving earlier gestational ages.
- 36. As described above, these conditions frequently require emergency care, including abortion, and given these nationwide numbers, it is not surprising that pregnant patients in Idaho are among persons who require treatment for medical conditions that frequently present as medical emergencies. For example, Idaho providers made claims to Medicaid and the Children's Health Insurance Program ("CHIP") for payment for: 98 ectopic pregnancies that were treated with pregnancy termination in 2018; 72 ectopic pregnancies were treated with pregnancy termination in 2019; 103 ectopic pregnancies were treated with pregnancy termination in 2020; and 108 ectopic pregnancies were treated with pregnancy termination in 2021. Notably, these numbers are based only on patients who are Medicaid or CHIP beneficiaries, not all patients in Idaho—which means the number of patients who presented with ectopic pregnancies in Idaho during those years is likely even higher overall.
- 37. As discussed above, similar treatment for ectopic pregnancy will no longer be available under Idaho's new abortion law. Based on the consistent historical data, it is a near-

certainty that patients with ectopic pregnancies will continue to require emergency medical treatment that qualifies as a prohibited "abortion" under Idaho law—just like the hundreds of patients who have needed that treatment in recent years. Without access to that treatment, the inevitable result for those patients will be substandard care and dire consequences for their health.

38. With respect to other emergency pregnancy conditions, including those described above in paragraphs 15-22, there is not similar readily available Medicaid/CHIP data. This does not reflect an absence of those conditions for patients in Idaho, but rather only the realities of how hospitals and other providers track diagnose/s and treatments, and how the federal government and private insurance companies reimburse for the costs of health care. However, based on my experience practicing medicine for more than 30 years, it is virtually certain that pregnant persons in Idaho present themselves in emergency rooms across the state each year with these emergency conditions and that the proper treatment in at least some cases would be termination of the pregnancy. Under the Idaho law, that treatment would be unavailable, and the consequence of denying that care to those patients will be tragic.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 8th day of August, 2022 in Philadelphia, PA.

Lee A. Fleisher, M.D.

# Exhibit B

### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

Defendant.

DECLARATION OF DR. EMILY CORRIGAN

# <u>DECLARATION OF DR. EMILY CORRIGAN IN SUPPORT OF THE UNITED</u> <u>STATES' MOTION FOR A PRELIMINARY INJUNCTION</u>

I, Emily Corrigan, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at Saint Alphonsus Regional Medical Center in Boise, Idaho. In that capacity, I specialize in, among other aspects of care, inpatient management of complicated pregnancies and emergency assessment and management of pregnant women. Saint Alphonsus Regional Medical Center is a tertiary care medical center with a trauma designation and a Level 3 Neonatal Intensive Care Unit. Thus, it is a regional referral center for complicated pregnancies and frequently cares for patients with traumatic injuries during pregnancy. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

- 2. I graduated from the University of California, San Francisco ("UCSF") School of Medicine in 2006 and subsequently completed my residency in Obstetrics and Gynecology at the University of Maryland Medical Center in 2011. I am Board Certified in General Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology.
- 3. In 2019, I moved to Idaho after accepting my current employment position as an Obstetric Hospitalist at Saint Alphonsus Regional Medical Center in Boise, Idaho. I have subsequently been elected to the position of Vice Chair of the Department of Obstetrics and Gynecology.
- 4. My family and I were drawn to Idaho for its natural beauty—including vast mountains and beautiful forests and all the recreation opportunities incumbent therein—along with its desirable pace of life and friendly communities. I also came to Idaho, in part, to fill a serious need for physicians generally, and especially Ob-Gyns, in the state.
- 5. There are zero residency programs in Obstetrics and Gynecology in the State of Idaho, meaning that all Ob-Gyns must be recruited from out of state. Idaho also has one of the fastest growing populations in the country. This dynamic has created a significant shortage of Ob-Gyns in our state.
- 6. Over the course of my nearly 15-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women and delivered thousands of healthy babies.
- 7. Although as physicians we work to help our patients to experience normal pregnancies, culminating in the delivery of a healthy baby, not all pregnancies are as simple and complication-free as physicians and patients would like.
- 8. At Saint Alphonsus Regional Medical Center, we do not perform purely elective abortions, which are abortions performed in pregnancies that do not seriously threaten the health

or life of the mother. However, there are situations where pregnancy termination in the form of an abortion is the only medical intervention that can preserve a patient's health or save their life. I will describe several recent examples of patients my colleagues and I have treated, which illustrate the dire circumstances that can make it medically necessary to terminate a pregnancy. Currently, our institution cares for patients in circumstances like these once every several months. However, I expect that this number will increase once Idaho Code § 18-622 goes into effect.

### Jane Doe 1

- 9. Jane Doe 1 is a woman in her mid-20s who lives in a rural part of the state hundreds of miles away from Boise. I treated her and the facts I describe here were either personal observations I made or facts relayed to me for the purpose of treating Jane Doe 1.
- 10. Jane Doe 1 has two children of her own. Like many other women in our state, she decided to become a surrogate (also called gestational carrier) to provide additional income for her family and to help others who are unable to produce their own children. The intended parent and biological father of Jane Doe 1's pregnancy lives overseas.
- 11. When Jane Doe 1 was at 19-weeks' gestation, she was diagnosed with a pregnancy complication called preterm premature rupture of membranes ("PPROM"). PPROM is a premature breaking open of the amniotic sac. It increases the risk of life-threatening intra-amniotic infection (chorioamnionitis) and also increases the risk that the fetus will not develop normally due to a decrease in the amount of amniotic fluid.
- 12. Jane Doe 1 consulted with her personal obstetrician after the diagnosis of PPROM but was not advised that evacuation of the uterus was appropriate or necessary. Instead, she was incorrectly advised that terminating the pregnancy was illegal in Idaho following the Supreme

Court's decision in *Dobbs* (which had occurred one week prior) due to Idaho's trigger law (even though Idaho Code § 18-622 was not yet in effect).

- 13. As her condition worsened, Jane Doe 1 spent several days in consultation with her surrogacy agency to determine her options. Eventually, she drove to Boise and presented to the emergency department at another hospital in the area. At this point, Jane Doe 1 had been experiencing cramps and chills for three days—signs of infection. The treating physician gave her oral antibiotics and told her to return to her regular physician in a week.
- 14. Administration of oral antibiotics and discharge home is not the medically accepted standard of care for suspected chorioamnionitis. At this point, Jane Doe 1 was experiencing an increased risk of sepsis (a life-threatening condition) and a deepening infection of the uterus that, in addition to the deficient amniotic fluid, would have a direct negative impact on the fetus. In such cases, evacuation of the uterus and intravenous ("IV") antibiotics is the only medically acceptable form of treatment.
- 15. Eventually, Jane Doe 1 presented to the Labor and Delivery Unit at Saint Alphonsus Regional Medical Center, where I first met her. She had been diagnosed with PPROM almost two weeks prior to presentation and had been experiencing worsening uterine cramping and chills for the past three days. I informed Jane Doe 1 that although fetal cardiac activity was still present, termination of pregnancy was the necessary course of action to preserve her life. The overseas intended parent for whom Jane Doe 1 was carrying the baby agreed with Jane Doe 1 that terminating the pregnancy was the best course of action due to the serious risks to both Jane Doe 1's life and the health of his future child. I discussed with her medical and surgical options for uterine evacuation, and she chose a medical termination.

- 16. Shortly after she was given medication to induce labor, Jane Doe 1 spiked a high fever. She delivered the fetus after several hours; however, the placenta would not detach from the uterus, causing her to start hemorrhaging. I transferred Jane Doe 1 to the operating room for a uterine curettage to remove the retained placenta. She was also given multiple medications to decrease the bleeding from her uterus. Still, she lost almost two liters of blood and required a blood transfusion. She was continued on IV antibiotics for another 24 hours and was discharged home in stable condition on hospital day number three.
- 17. Had Jane Doe 1 not received medical care to terminate her pregnancy, her intraamniotic infection would likely have led to sepsis thereby significantly increasing her chance of death.
- 18. If Idaho Code §18-622 was in effect when Jane Doe 1's case presented, I would have felt the need to consult with a lawyer in addition to the ethics and medical professionals I had already consulted in her case. This additional consultation would have further delayed Jane Doe 1's treatment in addition to taking me away from treating other patients in need.
- 19. Jane Doe's case illustrates an additional reason why Idaho Code § 18-622 is especially dangerous: Idaho's status as a destination for surrogacy. In my experience, Idaho has a very significant number of women who carry babies as surrogates. The prevalence of surrogacy in Idaho means that many pregnancies in the state are initiated through in vitro fertilization ("IVF") and are likely to be high-risk pregnancies that carry an increased risk of serious health complications for both the mother and the fetus.

### Jane Doe 2

20. One year and 8 months ago, Jane Doe 2 presented to an outlying hospital emergency department at 19-weeks' gestation experiencing significant bleeding. I eventually treated her and

the facts I describe here were either personal observations I made or facts relayed to me for the purpose of treating Jane Doe 2.

- 21. Jane Doe 2 was diagnosed with a placental abruption. This condition occurs when the placenta begins separating from the wall of the uterus before birth. Placental abruption decreases the blood and oxygen supply to the fetus and usually results in vaginal bleeding in the mother.
- 22. During the time she was under observation at the outside hospital, Jane Doe 2's condition worsened, and she developed disseminated intravascular coagulation ("DIC"). This is a dangerous condition that creates a high risk of death for the mother due to the rapid loss of large volumes of blood. Given that the outside hospital has minimal amounts of blood products in their blood bank, they requested to transfer Jane Doe 2 to Saint Alphonsus Regional Medical Center.
- 23. I first met Jane Doe 2 in the intensive care unit ("ICU") at Saint Alphonsus Regional Medical Center. The risk of her death at that point was imminent and the fetus still had a detectable heart rate by ultrasound. Although Jane Doe 2 was receiving multiple blood products at this point, her coagulation factors and anemia continued to worsen. The only medically acceptable action to preserve her life was immediate termination of the pregnancy.
- 24. An emergent dilation and evacuation procedure ("D&E") was advised, and Jane Doe 2 was taken to the operating room. The D&E procedure was uncomplicated. She remained intubated in the ICU overnight and continued to receive multiple blood products. By the next morning, the DIC had resolved and her anemia improved. Jane Doe 2 was transferred out of the ICU at that point and discharged from the hospital two days later.

25. Jane Doe 2's case illustrates the fact that some cases are so critical that there is simply no time to consult with a lawyer and debate, under the law, whether the proper medical standard of care should be used.

### Jane Doe 3

- 26. Ten months ago, Jane Doe 3 presented to the Emergency Department at an outside hospital at 17-weeks' gestation. She was suffering from shortness of breath and high blood pressure. Like Jane Doe 1, Jane Doe 3's pregnancy was the result of IVF. I did not personally treat Jane Doe 3, but I have studied her case in the normal course of my work as part of educational conferences in the Department of Obstetrics and Gynecology at Saint Alphonsus Regional Medical Center.
- 27. After ruling out other conditions including COVID-19, pneumonia, and a blood clot in her lungs, Jane Doe 3 was diagnosed with pleural effusions, sometimes called "water on the lungs," a condition that causes fluid to accumulate between the tissues that line the lungs and chest. Further examination revealed that Jane Doe 3's pleural effusions were being caused by a case of preeclampsia with severe features. Her fetus had detectable cardiac activity.
- 28. Preeclampsia is a dangerous pregnancy complication that can result in serious and potentially fatal complications to both the mother and the fetus. It rarely occurs before 20-weeks' gestation. When it occurs before 20-week's gestation, as it did for Jane Doe 3, it is typically severe and carries a high risk of maternal and fetal death.
- 29. The only medically acceptable standard of care for preeclampsia with severe features in Jane Doe 3's case was to terminate the pregnancy through evacuation of the uterus. She underwent an urgent D&E procedure. The pleural effusions and high blood pressure immediately

began to improve after the pregnancy termination, and she was discharged home in stable condition several days later.

30. Had Idaho Code § 18-622 been in effect, my colleague, Jane Doe 3's treating physician, would have been in the position of assessing her own legal liability instead of simply assessing the patient's best interest.

### Idaho Code § 18-622 and the Impact on Providers and Patients

- 31. Idaho Code § 18-622 is already harming women in Idaho. Specifically, in my experience as I describe above, the threat of criminal prosecution has already deterred doctors from providing medically necessary, life-saving care.
- 32. Idaho Code § 18-622 is also making it even more difficult to recruit Ob-Gyns to the State of Idaho. As I said, we already have a shortage of Ob-Gyns in Idaho. Idaho Code § 18-622 places physicians in a very difficult position because of a conflict between the State law and our ethical obligations to patients and our obligations under Federal law. If an Ob-Gyn can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here. In fact, at least one of my colleagues has already decided to stop her part-time work at our hospital due to the stress of complying with this law.
- 33. In addition, in emergency situations, many of which present in the middle of the night, physicians often do not have time to consult with lawyers about whether a decision they believe is warranted by the standard of care and therefore in the best interest of their patient will result in a financially ruinous investigation into their practice or in criminal liability. Also, time spent by physicians in court defending their medical decisions will keep them from their clinical duties for significant periods of time. This will add to the shortages in hospital and clinic coverage, increasing the workload of their practice partners as well as increasing wait times for patients.

- 34. The fact that a doctor can defend herself in a criminal prosecution does not give me any comfort about the way the law will negatively affect patient care. Having to defend against such a case alone would be incredibly burdensome, stressful, costly, and accordingly, means that the availability of a defense really does not solve the problems presented by the law.
- 35. Idaho Code § 18-622's threatens to criminalize abortion, even in many medically necessary circumstances, in a state where there is both a shortage of qualified physicians and a disproportionate number of high-risk pregnancies. This puts the health of Idaho women at significant risk.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

 $\frac{8/8/2Z}{Date}$ 

Emily Corrigan, M.D.

# **Exhibit C**

### UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

Defendant.

DECLARATION OF KYLIE COOPER, M.D.

# <u>DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES'</u> <u>MOTION FOR A PRELIMINARY INJUNCTION</u>

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

- 1. I am a double board-certified Obstetrician-Gynecologist ("Ob-Gyn") and Maternal-Fetal Medicine ("MFM") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in high-risk obstetrics. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.
- 2. I graduated from the University of Iowa Carver College of Medicine and subsequently completed my residency in Obstetrics and Gynecology at the University of Vermont. Following residency, I completed my Maternal-Fetal Medicine Fellowship at the University of Vermont. I am the current vice chair of the Idaho section of the American College of Obstetricians and Gynecologists (ACOG). I am teaching faculty for the Primary Care Obstetrics Fellowship with

Full Circle Health Family Medicine Residency which is a program to train family medicine physicians in obstetrical care to be used in their rural practice settings. This is particularly important given that there are no residency programs in OB/Gyn in Idaho. I also serve as an advisory board member for the Idaho Perinatal Project. My professional memberships include ACOG, the Society of Maternal-Fetal Medicine, and the Idaho Medical Association.

3. I came to Idaho specifically for my job as a maternal-fetal medicine physician at St. Luke's Regional Medical Center. As I was interviewing for MFM positions around the country it was clear that Idaho had a great need for high-risk obstetricians given the growing population and multitude of health conditions and pregnancy complications, such as obesity which impacts pregnancy in a multitude of ways. Additionally, there were very few female MFM physicians in Idaho, and I wanted to provide high quality and compassionate care to Idahoan families.

## Idaho Code § 18-622 and the Impact on Providers and Patients

- 4. Over the course of my seven-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women and delivered innumerable babies.
- 5. Pregnancy is not always straight forward and complication free. As an MFM physician my goal is to achieve the healthiest outcomes possible for my patients; however, there are many situations where pregnancy termination is the medically indicated treatment and is in the best interest of the patient's health and life. I will describe several recent examples of patients whom I have treated, which illustrate some circumstances that make it medically necessary to terminate a pregnancy. These cases occurred between September 2021 and June 2022.

### Jane Doe 1

6. Jane Doe 1 presented to the emergency department at 15 weeks gestation feeling unwell and was found to have severe range blood pressures. Her fetus had recently been diagnosed

with triploidy, a chromosomal abnormality with an entire extra set of chromosomes leading to multiple severe birth defects and though there was a fetal heartbeat, this condition was not compatible with life. Fetal triploidy carries an increased risk of development of preeclampsia in the mother. She was admitted to the hospital with persistent stroke range blood pressures requiring high dose antihypertensive therapy and magnesium to reduce her risk for seizures. A diagnosis of preeclampsia with severe features was made. The only cure for preeclampsia is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. The medical treatment for preeclampsia with severe features in patients who are at a previable gestational age is termination of pregnancy. Given her severe illness placing her at risk for stroke, seizure, pulmonary edema, development of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life.

7. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

#### Jane Doe 2

8. Jane Doe 2 presented to the emergency room at 20 weeks gestation with acute and progressive right upper abdominal pain requiring intravenous narcotics. Her pregnancy was complicated by a recent diagnosis of severe intrauterine growth restriction and though there was a fetal heartbeat, there was abnormal amniotic fluid level and abnormal umbilical cord blood flow portending a poor prognosis. She was found to have elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Her labs quickly deteriorated as would be expected with HELLP syndrome. Her platelets were dropping so quickly she required a platelet transfusion; she had evidence of hemolysis and concern for liver injury based on rising liver

enzymes and upper abdominal pain. HELLP syndrome placed her at risk for Disseminated Intravascular Coagulation (DIC) which is a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The only cure is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. In the setting of pre-viable HELLP syndrome, urgent termination of pregnancy is the necessary treatment to stop her disease progression to preserve her health and life.

9. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

#### Jane Doe 3

- 10. Jane Doe 3 presented to the emergency room at 15 weeks gestation with acute onset severe abdominal pain. She was noted to be hypertensive and lab abnormalities were consistent with a diagnosis of HELLP syndrome. Additionally, fetal and placental ultrasound was concerning for anomalies most consistent with fetal triploidy, a lethal fetal condition. Her abdominal pain and rapidly rising liver enzymes were indicative of liver injury, and her platelets were declining rapidly. In the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The medically necessary treatment to stop her disease progression and protect her health and life was termination of pregnancy.
- 11. The only medically acceptable action to preserve her health and life was to terminate the pregnancy.
- 12. Prior to Idaho's trigger law, my medical training and judgment allowed me to promptly identify what the appropriate standard of care treatment was for these patients. I was

able to expeditiously care for them in the appropriate manner to prevent long-term harm. The trigger law threatens to criminalize medically indicated termination of pregnancy. In the future, though I know what the appropriate medical treatment is for my patients, I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

9/8/2022 Date Kylie Cooper MD

# **Exhibit D**

## UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

Case No. 1:22-cv-329

v.

THE STATE OF IDAHO,

DECLARATION OF STACY T. SEYB, M.D.

Defendant.

# <u>DECLARATION OF STACY T. SEYB, M.D., IN SUPPORT OF THE UNITED STATES'</u> <u>MOTION FOR A PRELIMINARY INJUNCTION</u>

I, Stacy T. Seyb, M.D., being first duly sworn under oath, state and depose upon personal knowledge as follows:

- 1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in Maternal-Fetal Medicine. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.
- 2. I graduated from University of Kansas and subsequently completed my residency in Obstetrics and Gynecology at the University of Colorado and fellowship in Maternal Fetal Medicine at Northwestern University Feinberg School of Medicine. I practiced as a general Ob-Gyn and served as teaching faculty before completing my fellowship specializing in high risk and abnormal pregnancy management.

3. I have practiced as a Maternal-Fetal Medicine provider in Idaho for 22 years working not only on the front lines treating complicated pregnancies but also as a consultant to general OB-Gyn providers and Family Medicine providers providing obstetric care primarily in Southwest Idaho as well as across the state. I worked over a decade with the Idaho March of Dimes improving programming support and updating providers on evolving practices to improve the health of women and children in our state. Currently I serve as a state liaison to Idaho for the Society for Maternal Fetal Medicine.

## Idaho Code § 18-622 and the Impact on Providers and Patients

- 4. Over the course of my nearly 35-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women, delivered thousands of healthy babies, and managed a variety of life-threatening conditions in pregnancy.
- 5. Although as physicians we work to help our patients to experience normal pregnancies, culminating in the delivery of a healthy baby, not all pregnancies are as simple and complication-free as physicians and patients would like.
- 6. In the practice of Ob-Gyn, there are situations where pregnancy termination is the only medical intervention that can preserve a patient's health or save their life. Abortion is a very important tool that has contributed to the reduction of the maternal mortality rate from nearly 800 to 25 deaths per 100,000 live births across the United States in the last century. Obstetrics & Gynecology: November 2019 Volume 134 Issue 5 p 1105-1108. I will describe examples of patients my colleagues and I have treated, which illustrate the dire circumstances that can make it medically necessary to terminate a pregnancy. My colleagues and I encounter these pregnancy-related emergencies approximately a dozen times per year.

#### Jane Doe 1

- 7. A 22-year old woman at 18 weeks of her pregnancy presented to the Emergency Department and a Medical Screening Exam was remarkable for fever, tender uterus, elevated heart rate and evidence of an intrauterine infection without other obvious sources of infection. Her history was also suspicious, she may have ruptured her bag of water 10 days prior, and ultrasound confirmed both a fetal heartbeat as well as no fluid around the baby confirming that she has a condition termed Septic Abortion. While antibiotics are important for treating severe infections, a general tenet of medicine is that without drainage or removal of infected tissue the infection is unlikely to improve.
- 8. Had Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high. If she survived, other risks of not removing the infection include infertility or hysterectomy, as well as other sequala of sepsis including renal failure and clotting disorder, also known as Disseminated Intervascular Coagulation (DIC). The national standard for treating this condition is both antibiotics and emptying the contents of the uterus.

#### Jane Doe 2

9. A 35-year old woman presented to the Emergency Department with headache, vision changes, and feeling poorly for a few days. A Medical Screening Examination revealed severe range blood pressures, and laboratory values that were consistent with a pregnancy condition known as pre-eclampsia with severe features. Ultrasound revealed a fetal heartbeat but the fetus was small for dates and the placenta was large, consistent with what is termed a partial molar pregnancy.

10. The only medically acceptable action to preserve her life was termination of the pregnancy. Not only was the pregnancy ultimately not viable due to the nature of the molar pregnancy but removal of the placenta, i.e., delivery was the only cure to reverse the severe preeclampsia.

#### Jane Doe 3

- 11. A 25-year old woman in her 19<sup>th</sup> week of pregnancy presented to the Emergency Department after she started bleeding very heavily per vagina. The Medical Screening Examination indicated hypovolemic shock due to her blood loss. Initial resuscitation improved her condition but she continued to bleed in an uncontrolled manner. Although there was a fetal heartbeat present, without further treatment the bleeding was likely to continue. A Dilation and Evacuation (D and E) was performed, terminating the pregnancy.
- 12. The only medically available tool to stop the bleeding was termination of the pregnancy. If left untreated the risks of life-threatening shock, even with blood replacement were very high.
- 13. Idaho Code § 18-622 threatens to criminalize abortion, without clear definition of medically necessary circumstances. The assertion that "prevent the death of the pregnant woman" is clear to the medical community is not useful to medical providers because this is not a dichotomous variable.

In the three cases above, the medical standard was clear and if the trigger law goes into effect, providers will likely delay care for fear of criminal prosecution and loss of licensure. For example, as a high-risk pregnancy consultant, I recently received a call from an outside institution where the provider encountered a woman at 20-weeks of gestation, with severe bleeding similar to the one described above, and wanted to transfer her. He was qualified but was afraid of the potential

ramifications of his actions if he proceeded with termination. It was clear that the mother was in danger and that treatment could not be delayed. This situation was clear that termination was the only option, and I reassured this provider and recommended that management. This is one example that providers do not have a clear guide as to what situations will place their livelihood in danger. Providers from all over the state are voicing that they cannot rely upon their medical judgment or best practices for handling pregnancy complications.

14. Idaho Code § 18-622 threatens to make it difficult to recruit Ob-Gyns to the State of Idaho, where we have no in-state training for this specialty. In emergency situations, physicians may delay the medically necessary care because they fear a financially ruinous investigation or criminal liability. If an Ob-Gyn can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

Date

# Exhibit E

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

United States of Ame	erica,	)	
	Plaintiff,	)	Case No. 1:22-cv-329-BLW
v.		)	
The State of Idaho,		)	
	Defendant.	) )	

#### DECLARATION OF DAVID R. WRIGHT

- I, David R. Wright, of the Centers for Medicare & Medicaid Services ("CMS") declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the course of my official duties.
- 1. I am the Director of the Quality, Safety & Oversight Group ("QSOG") in the CMS Center for Clinical Standards & Quality ("CCSQ"), United States Department of Health and Human Services ("HHS"). QSOG provides guidance to state survey agencies and accrediting organizations that evaluate Medicare health and safety standards for providers on behalf of CMS. One of these Medicare health and safety standards is the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd.
- 2. Hospitals apply to become Medicare-certified by completing a CMS Form 855, Medicare Enrollment Application (<a href="https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf">https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf</a>).
- 3. Once the 855 form is submitted and approved, there is a certification process, designed to determine whether a hospital complies with the standards required by Federal law and

regulation, including Medicare Conditions of Participation ("CoPs"). 42 C.F.R. pt. 482 and 2 C.F.R. pt. 485.

- 4. If approved for Medicare certification, the hospital receives a CMS Form 1561-Health Insurance Benefit Agreement, which is signed by both the hospital and CMS (on behalf of the Secretary of HHS). <a href="https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1561.pdf">https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1561.pdf</a>. The CMS Form 1561 states that "...the provider of services, agrees to conform to the provisions of section 1866 of the Social Security Act and applicable provisions in 42 CFR," which includes EMTALA.
- 5. The hospital additionally submits an assurance of compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended.
- 6. Similar to the affirmations above, when a hospital submits its Medicare cost report following the completion of its fiscal years, the Chief Financial Officer or hospital Administrator must certify that he or she is "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations," which include EMTALA. See <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf</a>
- 7. All of the attestations on these forms and reports discussed above—including the CMS Form 1561, the assurance of compliance with nondiscrimination laws, and the certification on the hospital's Medicare cost report—are essential to the functioning of the Medicare program. CMS reimburses providers only upon the understanding that those providers are complying with the statutes and regulations governing the program.
- 8. There are 52 Medicare-participating hospitals in Idaho. 39 of these hospitals filed claims with CMS for emergency room costs on their Medicare cost reports.
- 9. There are sixteen government-owned hospitals that participate in Medicare in Idaho.

  State Hospital South (Blackfoot, Idaho) is a psychiatric hospital owned by the State of Idaho.

  Additionally, Madison Memorial Hospital (Rexburg, Idaho), Kootenai Health (Coeur d'Alene,

  Idaho), Bear Lake Memorial Hospital (Montpelier, Idaho), Benewah Community Hospital (St.

Maries, Idaho), Caribou Medical Center (Soda Springs, Idaho), Cascade Medical Center (Cascade, Idaho), Lost Rivers Medical Center (Arco, Idaho), Minidoka Memorial Hospital (Rupert, Idaho), Nell J. Redfield Memorial Hospital (Malad, Idaho), Power County Hospital District (American Falls, Idaho), Shoshone Medical Center (Kellogg, Idaho), Steele Memorial Medical Center (Salmon, Idaho), Syringa General Hospital (Grangeville, Idaho), Valor Health (Emmett, Idaho), and Weiser Memorial Hospital (Weiser, Idaho) are county-owned hospitals. All of the above-listed hospitals, with the exception of State Hospital South, have filed cost reports that include emergency department costs.

- 10. Medicare participating hospitals must meet the requirements of the EMTALA statute enacted as Section 1867 of the Social Security Act (42 U.S.C. § 1395dd), the accompanying regulations in 42 CFR § 489.24, and the related requirements at 42 CFR § 489.20(l), (m), (q), and (r). EMTALA requires hospitals with emergency departments to provide an appropriate medical screening examination to any individual who comes to the emergency department and requests such an examination. And EMTALA prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The term "hospital" includes critical access hospitals, which are typically smaller hospitals in rural communities that provide limited inpatient and outpatient services.
- 11. Some obligations under EMTALA apply only to Medicare-participating hospitals that have a dedicated emergency department, e.g., requirements related to providing a medical screening examination and any necessary stabilizing treatment. However, some EMTALA recipient hospital obligations, such as the obligation to provide stabilizing treatment, can also apply to Medicare-participating hospitals that do not have a dedicated emergency department, such as a hospital with specialized capabilities or facilities.

- 12. A hospital's EMTALA obligations apply both when a patient presents to the emergency department directly or by way of a transfer¹ from another medical provider. A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual with an unstabilized emergency medical condition that requires such specialized capabilities or facilities. Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units, or hospitals that are regional referral centers that serve rural areas as defined by the requirements at 42 CFR 412.96. This requirement to accept a transfer applies to any Medicare-participating hospital with specialized capabilities that has appropriate staff and facilities available to treat the condition, regardless of whether the hospital has a dedicated emergency department.
- 13. The goal of CMS' health and safety oversight is compliance with the Medicare CoPs and EMTALA, which themselves have the object of ensuring adequate care and advancing beneficiary and general patient health and safety. 42 CFR § 489.53(b) provides the basis for termination of a hospital's Medicare provider agreement for failure to comply with the requirements of EMTALA.
- 14. Through the passage of EMTALA, Congress obligated the Secretary of HHS to enforce the statute to protect any individual coming to the emergency department requesting examination or treatment for an emergency medical condition. As previously noted, CMS conditions the receipt of Medicare money, in part, on compliance with the EMTALA statute.
- 15. HHS cannot meet its Congressional EMTALA mandate if state law prohibits providers from providing the full range of care contemplated by the statute. Enforcing EMTALA aligns with the missions of HHS and CMS, of which protecting and promoting access to healthcare and emergency care are paramount.

<sup>&</sup>lt;sup>1</sup> A Medicare-participating hospital's EMTALA obligations apply regardless of how a patient arrives at its emergency department. However, in cases where a patient has arrived at that hospital through an inappropriate transfer from another Medicare-providing hospital, the receiving facility should also report the inappropriate transfer to CMS. 42 U.S.C. §1395(d)(2)(B).

- 16. EMTALA assists in protecting those objectives while requiring healthcare providers to render care to all individuals presenting to an emergency department that accepts Medicare funding, regardless of their medical condition, ability to pay for medical services, or directly conflicting state laws.
- 17. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8th day of August, 2022 in Baltimore, Maryland.

David R. Digitally signed by David R. Wright -S Date: 2022.08.08 16:09:29 -04'00'

David Wright
Director
Quality, Safety, and Oversight Group
Centers for Clinical Standards & Quality
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

# Exhibit F

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,	)
Plaintiff,	)
V.	) Civ. Action No. 1:22-cv-329
THE STATE OF IDAHO,	) ) )
Defendant.	) ) )

#### **DECLARATION OF BARBARA SHADLE**

- I, Barbara Shadle, declare as follows:
- 1. I am an Auditor within the Division of Provider Audit Operations ("DPAO") in the Centers for Medicare and Medicaid Services ("CMS") within the United States Department of Health and Human Services ("HHS"). DPAO is an office within the Financial Services Group of CMS Office of Financial Management. DPAO oversees and coordinates the Medicare cost report audit and reimbursement process, in order to ensure that payments made to institutional providers are accurate. I have held this position since 2018. In my role, I regularly communicate with Medicare Administrative Contractors ("MACs"), which are private insurance companies acting on behalf of CMS that process Medicare claims and cost reports and determine payment amounts to providers. I also review Medicare cost report reimbursement issues. The statements made in this declaration are based on my personal knowledge, information I obtained from DPAO support contractors, and information contained in cost reports submitted by Medicare providers.

- 2. Institutional providers include hospitals, critical care facilities, and skilled nursing centers. Institutional providers participating in the Medicare program are required to submit a Medicare cost report following the completion of their fiscal years. This Medicare cost report contains the provider's costs, charges, and financial information used to establish the provider's Prospective Payment rates and final Medicare reimbursement.
- 3. The first page of each provider's submitted cost report requires the Chief Financial Officer or hospital Administrator to certify that he or she is "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations." A copy of the certification form that must be completed and certified by participating providers is included as Exhibit 1.
- 4. The laws and regulations to which the certification refers include the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, as well as other portions of the Social Security Act and accompanying regulations.
- 5. This certification carries legal consequences. In highlighted capital letters, the form warns: "Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil, and administrative action, fine, and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative fines and/or imprisonment may result."
- 6. I was asked to identify the amount of Medicare funds provided to hospital emergency departments in Idaho. Based on the data available and supplied by a DPAO support services contractor, I have determined that the total rough estimate of emergency department

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payments in Idaho during fiscal years 2018-2020 was approximately \$74,739,853 out of the

providers' total payments of \$3,413,768,066. This total rough estimate was calculated for 39

hospitals as to which costs were able to be identified for emergency department services via data

in the Healthcare Cost Report Information System ("HCRIS").

7. The DPAO support services contractor identified this data regarding Medicare

payments in Idaho based on finalized cost report information that is loaded to HCRIS where it is

housed and can be accessed by CMS for Medicare rate-setting purposes.

8. In institutional providers' cost reports, providers identify their total hospital costs

and costs attributable to their emergency departments. See Ex. 1, Worksheet A. To determine a

rough estimate of emergency department payments, the emergency department costs were

divided by total hospital costs to determine a percentage related specifically to the emergency

department. I then multiplied this percentage by the hospital's total payments to reach the rough

estimate of payments related to emergency department services identified above in paragraph 6.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 8<sup>th</sup>

day of August, 2022 in Baltimore, Maryland.

Barbara Shadle Digitally signed by Barbara Shadle Date: 2022.08.08 17:27:15 -04'00'

Barbara Shadle

BRIAN M. BOYNTON

Principal Deputy Assistant Attorney General

BRIAN D. NETTER

Deputy Assistant Attorney General

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Counsel for Plaintiff

United States of America

[Additional counsel listed below]

# UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff.

Case No. 1:22-cy-329

v.

**COMPLAINT** 

THE STATE OF IDAHO,

Defendant.

The United States of America, by and through its undersigned counsel, brings this civil action for declaratory and injunctive relief, and alleges as follows:

#### PRELIMINARY STATEMENT

- 1. Under federal law, hospitals that receive federal Medicare funds are required to provide necessary stabilizing treatment to patients who arrive at their emergency departments while experiencing a medical emergency. Under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, if a person with an "emergency medical condition" seeks treatment at an emergency department at a hospital that accepts Medicare funds, the hospital must provide medical treatment necessary to stabilize that condition before transferring or discharging the patient. Crucially, "emergency medical conditions" under the statute include not just conditions that present risks to life but also those that place a patient's "health" in "serious jeopardy" or risk "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part."
- 2. In some circumstances, medical care that a state may characterize as an "abortion" is necessary emergency stabilizing care that hospitals are required to provide under EMTALA. Such circumstances may include, but are not limited to, ectopic pregnancy, severe preeclampsia, or a pregnancy complication threatening septic infection or hemorrhage.
- 3. The State of Idaho, however, has passed a near-absolute ban on abortion. Once the Idaho law takes effect on August 25, 2022, Idaho Code § 18-622 will make it a felony to perform an abortion in all but extremely narrow circumstances. The Idaho law would make it a criminal offense for doctors to comply with EMTALA's requirement to provide stabilizing treatment, even where a doctor determines that abortion is the medical treatment necessary to prevent a patient from suffering severe health risks or even death.
- 4. Under the Idaho law, once effective, any state or local prosecutor can subject a physician to indictment, arrest, and prosecution merely by showing that an abortion has been performed, without regard to the circumstances. The law then puts the burden on the physician to prove an "affirmative defense" at trial. Idaho Code § 18-622(3) (2022). Nothing protects a physician

from arrest or criminal prosecution under Idaho's law, and a physician who provides an abortion in Idaho can avoid criminal liability only by establishing that "the abortion was necessary to prevent the death of the pregnant woman" or that, before performing the abortion, the pregnant patient (or, in some circumstances, their parent or guardian) reported an "act of rape or incest" against the patient to a specified agency and provided a copy of the report to the physician. *Id.* Beyond care necessary to prevent death, the law provides no defense whatsoever when the health of the pregnant patient is at stake. And, even in dire situations that might qualify for the Idaho law's limited "necessary to prevent the death of the pregnant woman" affirmative defense, some providers could withhold care based on a well-founded fear of criminal prosecution.

- 5. Idaho's abortion law will therefore prevent doctors from performing abortions even when a doctor determines that abortion is the medically necessary treatment to prevent severe risk to the patient's health and even in cases where denial of care will likely result in death for the pregnant patient. To the extent Idaho's law prohibits doctors from providing medically necessary treatment, including abortions, that EMTALA requires as emergency medical care, Idaho's new abortion law directly conflicts with EMTALA. See 42 U.S.C. § 1395dd(f) (EMTALA preempts State laws "to the extent that the requirement directly conflicts with a requirement of this section"). To the extent Idaho's law renders compliance with EMTALA impossible or stands as an obstacle to the accomplishment of federal statutes and objectives, EMTALA preempts the Idaho law under the Supremacy Clause of the United States Constitution.
- 6. In this action, the United States seeks a declaratory judgment that Idaho's law is invalid under the Supremacy Clause and is preempted by federal law to the extent that it conflicts with EMTALA. The United States also seeks an order preliminarily and permanently enjoining Idaho's restrictive abortion law to the extent it conflicts with EMTALA.

#### **JURISDICTION AND VENUE**

- 7. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331 and 1345.
- 8. Venue is proper in this judicial district under 28 U.S.C. § 1391(b) because Defendant resides within this judicial district and because a substantial part of the acts or omissions giving rise to this action arose from events occurring within this judicial district.
- 9. Pursuant to D. Idaho Civ. R. 3.1, venue is proper in the Southern Division because Defendant legally resides in Ada County, Idaho, and because that is where the claim for relief arose.

#### **PARTIES**

- 10. Plaintiff is the United States of America.
- 11. Defendant, the State of Idaho, is a State of the United States. The State of Idaho includes all of its officers, employees, and agents.

#### **SUPREMACY OF FEDERAL LAW**

## I. The Supremacy Clause and Preemption

- 12. The Supremacy Clause of the U.S. Constitution mandates that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof... shall be the supreme Law of the Land... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2.
- 13. "[S]tates have no power . . . to retard, impede, burden, or in any manner control the operations of the Constitutional laws enacted by [C]ongress to carry into effect the powers vested in the national government." *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 317 (1819). "There is no doubt Congress may withdraw specified powers from the States by enacting a statute containing an express preemption provision," and a State law is invalid if it conflicts with such a provision. *Arizona v. United States*, 567 U.S. 387, 399 (2012). Likewise, a State law is invalid if compliance with the state

and federal law is impossible or if the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidovitz*, 312 U.S. 52, 67 (1941).

### II. The Emergency Medical Treatment and Labor Act (EMTALA)

- 14. Medicare, enacted in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., is a federally funded program, administered by the Secretary of the Department of Health and Human Services (HHS), that pays health care providers or insurers for health care services under certain circumstances.
- 15. Medical providers' participation in Medicare is voluntary. When providers agree to participate in Medicare, they submit provider agreements to the Secretary of HHS. *See* 42 U.S.C. § 1395cc. Hospitals submitting such agreements agree that they will "adopt and enforce a policy to ensure compliance with the requirements of [EMTALA] and to meet the requirements of [EMTALA]." *Id.* § 1395cc(a)(1)(I)(i).
- 16. Under EMTALA, hospitals participating in Medicare are generally required to provide stabilizing health care to all patients who arrive at an emergency department suffering from an emergency medical condition. *See* 42 U.S.C. § 1395dd.
- 17. Specifically, EMTALA requires these hospitals to "screen" patients who request treatment at the hospital's emergency department and provide "necessary stabilizing treatment," including an appropriate transfer to another facility that is able to provide stabilizing care not available at the originating hospital, for any "emergency medical condition" the hospital identifies. 42 U.S.C. § 1395dd.
- 18. The screening requirement necessitates that hospitals act "to determine whether or not an emergency medical condition" exists. *Id.* § 1395dd(a); *see also* 42 C.F.R. § 489.24(a) (noting that EMTALA requires "an appropriate medical screening examination within the capability of the hospital's emergency department").

- 19. Congress defined an "emergency medical condition" in EMTALA as:
- (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 ...
- (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.

42 U.S.C. § 1395dd(e)(1).

- 20. If the hospital determines an individual has an emergency medical condition, "the hospital must provide either" (1) "further medical examination and such treatment as may be required to stabilize the medical condition," or (2) "transfer of the individual to another medical facility in accordance with" certain requirements. *Id.* § 1395dd(b)(1); *see also* 42 C.F.R. § 489.24(a)(1)(i)-(ii). The hospital may also "admit[] th[e] individual as an inpatient in good faith in order to stabilize the emergency medical condition." 42 C.F.R. § 489.24(d)(2)(i).
- 21. EMTALA defines "to stabilize" to mean "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). The term "transfer" is defined to include "discharge" of a patient. *Id.* § 1395dd(e)(4).
- 22. A hospital may not transfer (including by discharging) an individual with an emergency medical condition who has not been stabilized, unless, *inter alia*, the individual requests a transfer or a

physician certifies that the benefits of a transfer to another medical facility outweigh the increased risks to the patient. *Id.* § 1395dd(c).

- 23. In short, when an emergency medical condition exists, EMTALA requires participating hospitals to provide "stabilizing" treatment, as determined by the particular hospital's facilities and the treating physician's professional medical judgment.
- 24. As relevant here, there are some pregnancy-related emergency medical conditions including, but not limited to, ectopic pregnancy, severe preeclampsia, or a pregnancy complication threatening septic infections or hemorrhage—for which a physician could determine that the necessary stabilizing treatment is care that could be deemed an "abortion" under Idaho law. <sup>1</sup> In that scenario, EMTALA requires the hospital to provide that stabilizing treatment. See Dep't of Health and Human Servs., Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss, CENTERS FOR MEDICARE & MEDICAID SERVICES (July 11, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf; see also Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss, CENTERS FOR MEDICARE & **MEDICAID** SERVICES 17, 2021), (Sept. https://www.cms.gov/files/document/qso-21-22-hospital.pdf.
- 25. EMTALA contains an express preemption provision, which preempts State laws "to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f).

<sup>&</sup>lt;sup>1</sup> Termination of an ectopic pregnancy—which can never lead to a live birth and poses inherent danger to pregnant patients—is not considered an abortion by medical experts. However, the termination of an ectopic pregnancy appears to fall within Idaho's broad definition of abortion. *See* Idaho Code § 18-604(1).

#### **IDAHO'S ABORTION LAW**

- 26. In 2020, Idaho enacted a law that severely restricts abortions and threatens criminal prosecution against anyone who performs an abortion. The law, codified at Idaho Code § 18-622, is currently set to take effect on August 25, 2022, which is 30 days after issuance of the judgment in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022). *See* Idaho Code § 18-622(1)(a).
- 27. Under Idaho's abortion law, "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion." *Id.* § 18-622(2). The crime of "criminal abortion" is a felony, punishable by two to five years imprisonment. *Id.*
- 28. Idaho's law also requires that "[t]he 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." *Id.* (emphasis added).
- 29. The Idaho law defines "[a]bortion" to mean "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." *Id.* § 18-604(1).
- 30. The *prima facie* criminal prohibition in Idaho's law does not contain any exceptions for when the pregnant patient's health or life is endangered. Thus, the mere performance of an abortion—even in an emergency, life-saving scenario—would subject a provider to criminal prosecution and require the provider to raise one of the law's narrow affirmative defenses at trial.
- 31. Idaho's abortion law provides for only two affirmative defenses, either of which the provider must prove by a preponderance of the evidence. In other words, once a prosecutor or licensing authority proves the *prima facie* case of an abortion having been performed, an accused physician may try to avoid conviction, incarceration, and loss of license by raising one of two

affirmative defenses, but bears the burden of proving the defense to a jury, along with the expense and uncertainty that flow from that burden.

- 32. Specifically, the accused physician would have to prove to a jury: (1) that "[t]he 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," or (2) in cases of rape or incest, that the woman, or, if a minor, the woman or her parent or guardian, "has reported the act of rape or incest to a law enforcement agency" and the physician, prior to performing the abortion, received a copy of a police report (or, in the case of a minor, a police report or report to child protective services) regarding "the act of rape or incest." Idaho Code § 18-622(3)(a)(ii), (b)(ii)-(iii).
- 33. There is no affirmative defense applicable in circumstances where an abortion is necessary to ensure the health of the pregnant patient—even where the patient faces serious medical jeopardy or impairment—if the care is not "necessary to prevent the death" of the patient.
- 34. In addition, it is a requirement for both affirmative defenses, and thus the physician would have to prove, that 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." *Id.* § 18-622(3)(a)(iii), (b)(iv).

#### IDAHO'S ABORTION LAW CONFLICTS WITH EMTALA

35. Within the State of Idaho, there are approximately 43 hospitals that voluntarily participate in Medicare. Approximately 39 of those hospitals have emergency departments that are required to comply with EMTALA.

- 36. Idaho's criminal prohibition of all abortions, subject only to the statute's two limited affirmative defenses, conflicts with EMTALA. Idaho's criminal prohibition extends even to abortions that a physician determines are necessary stabilizing treatment that must be provided under EMTALA.
- 37. In particular, EMTALA's definition of an emergency medical condition—for which the hospital would be required to facilitate stabilizing treatment—is broader than just those circumstances where treatment is "necessary to prevent . . . death" under Idaho law. For example, EMTALA requires stabilizing treatment where "the health" of the patient is "in serious jeopardy," or where continuing a pregnancy could result in a "serious impairment to bodily functions" or a "serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii). Idaho has criminalized performing abortions in those circumstances, even when a physician has determined that an abortion is the necessary stabilizing treatment for a patient's emergency medical condition. The Idaho law therefore conflicts with federal law and is, in this respect, preempted.
- 38. The Idaho law also conflicts with EMTALA because the only limited protection it affords for even life-saving abortions is in the form of an affirmative defense where the provider bears the burden of proof at trial. Idaho's law subjects every provider who performs an abortion to the threat of indictment, arrest, and criminal prosecution. The law likewise subjects every provider and employee who performs or assists in performing an abortion to potential loss of their medical license. By threatening providers with criminal prosecution and license revocation proceedings for *every* abortion, regardless of whether it was "necessary to prevent . . . death," the Idaho law will deter physicians from performing abortions they have determined are medically necessary and thus must be provided under federal law. This is true even in the limited situations in which the abortions could be deemed defensible at a physician's criminal trial. "Where a prosecution is a likely possibility, yet only an affirmative defense is available," there "is a potential for extraordinary harm and a serious chill" upon protected conduct. *Asbaroft v. ACLU*, 542 U.S. 656, 670-71 (2004). Here, the law's obvious

chilling effect on providers' willingness to perform abortions, even when abortions are determined to be necessary medical treatments, is itself an impediment to the accomplishment of EMTALA's goal of ensuring that patients receive emergency care. The Idaho law is therefore preempted.

# IDAHO'S ABORTION LAW CAUSES INJURY TO FEDERAL INTERESTS

- 39. The Idaho abortion law will become effective on August 25, 2022.
- 40. Following the Supreme Court's decision in *Dobbs*, the Governor of Idaho issued a press release stating that "Idaho has been at the forefront of enacting new laws" to restrict abortion, and specifically referencing § 18-622 as a bill that the Governor "signed into law" and "will go into effect later this summer."<sup>2</sup>
- 41. Before filing this lawsuit, on July 29, 2022, the United States sent a letter to the State of Idaho, expressing the United States' view that § 18-622 was contrary to federal law. The United States did not receive a substantive response.
- 42. Once the law goes into effect on August 25, 2022, providers will immediately be subject to the threat of arrest, imprisonment, criminal liability, and loss of license for providing federally required care.
- 43. Severe harm will result from Idaho's law, which violates the Supremacy Clause. *See New Orleans Pub. Serv., Inc. v. Council of City of New Orleans*, 491 U.S. 350, 366-67 (1989) (assuming that irreparable injury may be established "by a showing that the challenged state statute is flagrantly and patently violative of . . . the express constitutional prescription of the Supremacy Clause" (citation omitted)).

#### I. Idaho's Abortion Law Threatens Severe Public Health Consequences

44. If Idaho's abortion law is allowed to take effect, physicians in Idaho will be threatened with prosecution under a state law that prohibits them from providing necessary stabilizing medical

<sup>&</sup>lt;sup>2</sup> https://gov.idaho.gov/pressrelease/gov-little-comments-on-scotus-overrule-of-roe-v-wade/

treatment required by EMTALA. Physicians will be faced with an untenable choice—either to withhold critical stabilizing treatment required under EMTALA or to risk criminal prosecution and potential loss of their professional licenses. As a result of Idaho's physicians being placed in this position, patients will suffer—including by having their care delayed or losing access to necessary health care that is guaranteed under federal law. Particularly in emergency circumstances, or when dealing with considerations of risk to an individual's life or health, delayed health care can pose serious harms and is exactly what EMTALA's requirements are designed to prevent. In short, the Idaho law threatens severe public health consequences.

- 45. For example, pregnant patients sometimes arrive at a hospital's emergency department with an emergency medical condition for which physicians reasonably determine that the appropriate stabilizing treatment is an emergency abortion. Physicians facing a threat of criminal prosecution for performing an emergency abortion may be reluctant to perform the procedure—even when their medical judgment leads them to conclude that the procedure is necessary. The loss of that necessary treatment will result in irreversible damage to the health of a pregnant patient in some instances, and in other cases could lead to death.
- 46. The Idaho law will deprive pregnant patients of necessary treatment required by EMTALA notwithstanding the Idaho law's affirmative defense for abortions "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(ii). Because that defense is available only during criminal prosecution or licensing proceedings, the law still subjects providers to the threat of criminal prosecution and potential loss of license for performing a life-saving abortion. And even the law's affirmative defense does not allow for abortions in emergency situations where pregnancy can reasonably be expected to place the health of the pregnant patient in serious jeopardy, seriously impair the pregnant patient's bodily functions, or cause serious dysfunction of any bodily part or organ.

# II. Idaho's Law Interferes with EMTALA Obligations under the Federal Medicare Program

- 47. As discussed above, Idaho's abortion law directly conflicts with the important federal policy reflected in EMTALA, 42 U.S.C. § 1395dd, through which Congress codified a guarantee of necessary stabilizing medical treatment for patients with emergency medical conditions, including pregnant patients, who seek care at emergency departments. *See id.* § 1395dd(a), (b), (e)(1), (g).
- 48. Congress intended EMTALA to govern nationwide in every hospital that accepts Medicare funds, as confirmed by its express preemption of conflicting State laws. *Id.* § 1395dd(f). Idaho's law frustrates Congress's objective of guaranteeing nationwide emergency medical care at Medicare hospitals, because Idaho law prohibits a particular form of medical treatment—even when that treatment is necessary to stabilize a patient experiencing an emergency medical condition. The United States has a strong sovereign interest in ensuring that States may not disrupt the federal objectives embodied in EMTALA, particularly when States seek to hold physicians criminally liable for providing stabilizing emergency treatment required under federal law.
- 49. The United States has an interest in protecting the integrity of the funding it provides under Medicare and ensuring that hospitals who are receiving Medicare funding will not refuse to provide stabilizing treatment to patients experiencing medical emergencies. From 2019 to 2020, HHS paid approximately 74 million dollars for emergency department care in Idaho hospitals enrolled in Medicare. A condition of hospitals' enrollment in Medicare is that they agree to comply with EMTALA. See id. § 1395cc(a)(1)(I)(i). Thus, part of the United States' bargain when it agrees to provide Medicare reimbursement to hospitals is that those hospitals will, in return, provide all forms of stabilizing treatment to emergency department patients, consistent with EMTALA.
- 50. Idaho's law prevents the United States from receiving the benefit of its bargain, however, by affirmatively prohibiting Idaho hospitals from complying with certain obligations under EMTALA. Thus, Idaho's law undermines the overall Medicare program and the funds that the United

States provides in connection with that program, by precluding the United States from receiving one of the benefits to which it is entitled under the Medicare program.

- 51. Idaho's law also improperly interferes with the United States' pre-existing agreements with hospitals under Medicare. Under these agreements, each hospital (including those in Idaho) must certify that it "agrees to conform to the provisions of section 1866 of the Social Security Act and applicable provisions in 42 CFR," CMS Form 1561, and those referenced provisions likewise include obligations to comply with EMTALA.<sup>3</sup>
- 52. Approximately 43 hospitals in Idaho have signed Medicare agreements, and approximately 39 of those hospitals have emergency departments that must comply with EMTALA. Compliance with Idaho's law would force these hospitals to violate their agreements with the United States because Idaho criminalizes the provision of stabilizing medical services required by EMTALA, and thus Idaho's law likewise interferes with the United States' interests.
- Waiting to initiate federal enforcement actions directly against physicians or hospitals would likely have significant negative consequences on public health, including because such actions could be pursued only after physicians or hospitals had first denied emergency care to an individual in need. Unless the action is filed against a state-run hospital, the State would not be a party to a federal enforcement action, and the State's absence would further delay the resolution of this issue. Meanwhile, patients would be denied important life-saving and stabilizing medical care, resulting in needless suffering and even loss of life. Physicians and hospitals should not be placed in the untenable position of risking criminal prosecution under state law or subjecting themselves to enforcement actions under federal law. Pregnant patients who arrive at an emergency department are entitled to the stabilizing emergency care ensured under federal law when experiencing life- or health-threatening conditions.

<sup>&</sup>lt;sup>3</sup> https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1561.pdf

54. The law likewise stands as an obstacle to Congress's goal of ensuring that patients receive effective emergency care by threatening the professional license of *any* health care professional who "assists" in performing or attempting to perform an abortion. Idaho Code § 18-622(2). In particular, the law threatens a six-month suspension of the license of any health care professional who assists in an abortion or, on a second offense, threatens to permanently bar these providers from their professional practice. A pregnant patient who arrives in the emergency department with an emergency condition is likely to encounter not just emergency department physicians but also triage nurses, scrub nurses, lab techs, radiologists, anesthesiologists, and others whose role in any procedure could constitute "assisting" in the performance of an abortion. By threatening the license of other hospital employees whose care is critical to providing emergency department care, Idaho's law impedes EMTALA's goal of ensuring that patients receive effective emergency care.

#### **CLAIM FOR RELIEF**

### Preemption Under the Supremacy Clause and EMTALA

- 55. Plaintiff hereby incorporates paragraphs 1 through 54 as if fully set forth herein.
- 56. The Supremacy Clause provides that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2.
- 57. EMTALA expressly preempts State laws "to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). Idaho Code § 18-622 violates the Supremacy Clause and is preempted to the extent it is contrary to EMTALA.
- 58. The law imposes requirements that are contrary to EMTALA and impedes the accomplishment and execution of the full purposes and objectives of federal law and is therefore preempted.

59. The Idaho law therefore violates the Supremacy Clause and is preempted under federal law to the extent that it conflicts with EMTALA.

#### **PRAYER FOR RELIEF**

WHEREFORE, the United States respectfully requests the following relief:

- a. A declaratory judgment stating that Idaho Code § 18-622 violates the Supremacy Clause and is preempted and therefore invalid to the extent that it conflicts with EMTALA;
- b. A declaratory judgment stating that Idaho may not initiate a prosecution against, seek to impose any form of liability on, or attempt to revoke the professional license of any medical provider based on that provider's performance of an abortion that is authorized under EMTALA;
- c. A preliminary and permanent injunction against the State of Idaho—including all of its officers, employees, and agents—prohibiting enforcement of Idaho Code § 18-622(2)-(3) to the extent that it conflicts with EMTALA;
- d. Any and all other relief necessary to fully effectuate the injunction against Idaho Code § 18-622's enforcement to the extent it conflicts with EMTALA;
- e. The United States' costs in this action; and
- f. Any other relief that the Court deems just and proper.

Dated: August 2, 2022

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# UNITED STATES DISTRICT COURT

#### DISTRICT OF IDAHO

UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF IDAHO,

Defendant.

Case No. 1:22-cv-00329-BLW

NOTICE OF APPEAL

Notice is hereby given that the State of Idaho, Appellant, hereby appeals to the United States Court of Appeals for the Ninth Circuit. The State of Idaho appeals the district court's May 4, 2023 Memorandum Decision and Order [135] denying the State of Idaho's motion to reconsider the district court's August 24, 2022 Memorandum Decision and Order [95] granting a preliminary injunction.

#### FORM 1 INFORMATION

- Date case was first filed in U.S. District Court: August 2, 2022
- Date of judgment or order being appealed: May 4, 2023 and August 24, 2022
- Docket entry number of judgment or order appealed from: 135 (Memorandum Decision and Order), 95 (Memorandum Decision and Order)
- Docketing fee of \$505 paid to the U.S. District Court for the District of Idaho.
- Appellant: State of Idaho
  - o This is not a cross-appeal
  - There is a pending appeal in this case. Its case number is 23-35153. The caption for this appeal is: UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STATE OF IDAHO, Defendant-Appellee, v. MIKE MOYLE, Speaker of the Idaho House of Representatives, et al., Movants-Appellants.
- A representation statement follows on the next page.

DATED: June 28, 2023.

STATE OF IDAHO OFFICE OF THE ATTORNEY GENERAL

By: /s/ Lincoln Davis Wilson

LINCOLN DAVIS WILSON Chief of Civil Litigation and Constitutional Defense

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# **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on June 28, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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/s/ Lincoln Davis Wilson
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APPEAL,LC17

# U.S. District Court District of Idaho (LIVE) NextGen 1.7 (Boise - Southern) CIVIL DOCKET FOR CASE #: 1:22-cv-00329-BLW

The United States v. State of Idaho Assigned to: Judge B Lynn Winmill

Case in other court: Ninth Circuit, 23-35153

Ninth Circuit Court of Appeals, 23-35440 Ninth Circuit Court of Appeals, 23-35450

Cause: 28:2201 Constitutionality of State Statute(s)

Date Filed: 08/02/2022 Jury Demand: None

Nature of Suit: 950 Constitutional - State

Statute

Jurisdiction: U.S. Government Plaintiff

### **Plaintiff**

**United States of America** 

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V.

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Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 266 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 267 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 268 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 269 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 271 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 272 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 273 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 276 of 292

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Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 277 of 292

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**Date Filed** 

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**Docket Text** 

Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 278 of 292

		25-554-0, 00/07/2025, ID. 12705951, DRIEHHY. 15-4, 1 age 270 of 252
08/02/2022	1	COMPLAINT against State of Idaho, filed by The United States. (Attachments: # 1 Cover Sheet, # 2 Cover Sheet Counsel attachment, # 3 Summons)(Newman, Lisa) (Attachment 1 cover sheet replaced with PDF that cannot be edited on 8/3/2022) (ac).
08/02/2022	2	NOTICE of Appearance by Anna Lynn Deffebach on behalf of All Plaintiffs (Deffebach, Anna)
08/02/2022	<u>3</u>	NOTICE of Appearance by Julie Straus Harris on behalf of The United States (Straus Harris, Julie)
08/03/2022	4	Summons Issued as to State of Idaho. (Print attached Summons for service.) (ac)
08/04/2022	<u>5</u>	NOTICE of Appearance by Daniel Schwei on behalf of United States of America (Schwei, Daniel)
08/04/2022	<u>6</u>	SUMMONS Returned Executed by United States of America. State of Idaho served on 8/2/2022, answer due 8/23/2022. (Newman, Lisa)
08/04/2022	7	NOTICE of Appearance by Christopher A. Eiswerth on behalf of United States of America (Eiswerth, Christopher)
08/04/2022	8	NOTICE of Appearance by Emily Nestler on behalf of United States of America (Nestler, Emily)
08/04/2022	9	NOTICE of Appearance by Megan Ann Larrondo on behalf of State of Idaho (Larrondo, Megan)
08/05/2022	<u>10</u>	NOTICE of Appearance by Brian David Netter on behalf of United States of America (Netter, Brian)
08/05/2022	11	NOTICE of Availability of Magistrate Judge and Requirement for Consent sent to counsel for State of Idaho, United States of America re 1 Complaint, 9 Notice of Appearance Consent/Objection to Magistrate due by 10/4/2022. (alw)
08/05/2022	<u>12</u>	NOTICE of Appearance by Steven Lamar Olsen on behalf of State of Idaho (Olsen, Steven)
08/05/2022	13	DOCKET ENTRY ORDER: In accordance with the agreement reached by the parties and discussed with the Court at an informal status conference, the following briefing schedule is ordered. The United States will file its motion for injunctive relief on Monday, August 8. The State of Idaho will file its response on Tuesday, August 16. The United States will file its reply brief by 12:00 pm MDT on Friday, August 19. The Court will have a hearing on the motion, which will be set by separate notice, on August 22. Signed by Judge B Lynn Winmill. (hgp)
08/05/2022	21	Docket Text Minute Entry for proceedings held before Judge B Lynn Winmill: A Status Conference was held via Zoom on 8/5/2022. Appearing on behalf of Plaintiff: Lisa Newman, Daniel Schwei, and Brian Netter. Appearing on behalf of Defendant: Megan Larrondo and Steve Olsen. The Court discussed a briefing schedule regarding Plaintiff's motion for injunctive relief (see Dkt. 13). Hearing was held informally and was not recorded. Time: 1:04-1:14p.m. (jlg) (Entered: 08/10/2022)
08/08/2022	14	ORDER. An amicus curiae supporting the United States of America must file its brief, accompanied by a motion for filing, no later than August 15, 2022. An amicus curiae supporting the State of Idaho must file its brief, accompanied by a motion for filing, no later than 12:00 MDT on August 19, 2022. An amicus curiae that does not support either party must file its brief no later than no later than 12:00 MDT on August 19, 2022. Signed by Judge B Lynn Winmill. (alw)

Case: 23-35440, 08/07/2023, ID: 12769991, DktEntry: 13-4, Page 279 of 292

		25-55440, 00/07/2025, ID. 12709991, DKILITITY. 15-4, 1 age 279 01 292
08/08/2022	15	Expedited MOTION to Intervene Daniel W. Bower, Monte N Stewart appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 8/29/2022 (Attachments: # 1 Memorandum in Support of Motion to Intervene, # 2 Exhibit 1 Proposed Answer)(Bower, Daniel)
08/08/2022	<u>16</u>	MOTION to Expedite <i>Idaho Legislatures Motion to Intervene</i> Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 8/29/2022 (Bower, Daniel)
08/08/2022	17	MOTION for Preliminary Injunction Lisa Newman appearing for Plaintiff United States of America. Responses due by 8/29/2022 (Attachments: # 1 Memorandum in Support, # 2 Proposed Order, # 3 Ex. A, Fleisher Declaration, # 4 Fleisher Appendix, Pt. 1, # 5 Fleisher Appendix, Pt. 2, # 6 Ex. B, Corrigan Declaration, # 7 Ex. C, Cooper Declaration, # 8 Ex. D, Seyb Declaration, # 9 Ex. E, Wright Declaration, # 10 Ex. F, Shadle Declaration, # 11 Ex. G, Newman Declaration, # 12 Newman Appendix, Pt. 1, # 13 Newman Appendix, Pt. 2)(Newman, Lisa)
08/09/2022	18	DOCKET ENTRY ORDER: The parties shall respond to the motion to intervene (Dkt. <u>15</u> ) by Wednesday, August 10, 2022. Signed by Judge B Lynn Winmill. (hgp)
08/09/2022	<u>19</u>	AMENDED ORDER re 14 Order. Signed by Judge B Lynn Winmill. (alw)
08/10/2022	<u>20</u>	NOTICE by State of Idaho re <u>15</u> Expedited MOTION to Intervene <i>State of Idaho's Non-Opposition</i> (Larrondo, Megan)
08/10/2022	22	DOCKET ENTRY NOTICE OF HEARING regarding 17 Motion for Preliminary Injunction: A Motion Hearing is set for 8/22/2022 at 9:30 AM in Boise - Courtroom 2 before Judge B Lynn Winmill. (jlg)
08/10/2022	23	RESPONSE to Motion re 15 Expedited MOTION to Intervene filed by United States of America. Replies due by 8/24/2022.(Deffebach, Anna)
08/11/2022	24	DOCKET ENTRY ORDER: If the Idaho Legislature wishes to file its optional reply brief in support of its motion to intervene (filed at Dkt. 15), it must do so by 5:00 p.m. Mountain Time today, August 11, 2022. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (mls)
08/11/2022	<u>25</u>	REPLY to Response to Motion re 15 Expedited MOTION to Intervene filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature.Motion Ripe Deadline set for 8/12/2022.(Bower, Daniel)
08/12/2022	<u>26</u>	NOTICE of Appearance by Brian V Church on behalf of State of Idaho (Church, Brian)
08/13/2022	27	MEMORANDUM DECISION AND ORDER granting in part and denying in part 15 Motion to Intervene. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (mls)
08/15/2022	28	DOCKET ENTRY ORDER: The Court amends its oral order, made during the informal status conference today, as follows: The Legislature's deadline for submitting affidavits in supports of its response shall be due by 12:00 p.m., Mountain Time, on Wednesday, August 17, 2022. The Legislature's deadline to submit its brief opposing the United States Motion for Preliminary Injunction shall remain the same: that brief is due on August 16,
		3-ER-409

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		2022. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (mls)
08/15/2022	29	AMENDED DOCKET ENTRY NOTICE OF HEARING regarding 17 Motion for Preliminary Injunction: The Motion Hearing set for 8/22/2022 is rescheduled to begin at 9:00 AM in Boise - Courtroom 2 before Judge B Lynn Winmill. (jlg)
08/15/2022	<u>30</u>	Minute Entry for proceedings held before Judge B Lynn Winmill: Video Status Conference was held on 8/15/2022. (Court Reporter Tammy Hohenleitner.) (jlg)
08/15/2022	31	NOTICE of Appearance by Joan Elizabeth Callahan on behalf of State of Idaho (Callahan, Joan)
08/15/2022	32	MOTION FOR PRO HAC VICE APPEARANCE by Laura Etlinger. (Filing fee \$ 250 receipt number AIDDC-2435922.) Laura Etlinger appearing for Amicus Parties New York, State of, California, State of, Connecticut, State of, Colorado, State of, Delaware, State of, Hawaii, State of, Illinois, State of, Maine, State of, Maryland, State of, Massachusetts, State of, Michigan, State of, Minnesota, State of, Nevada, State of, New Jersey, State of, New Mexico, State of, North Carolina, State of, Oregon, State of, Pennsylvania, State of, Rhode Island, State of, Washington, State of, Washington DC. Responses due by 9/6/2022 (Etlinger, Laura)
08/15/2022	33	MOTION FOR PRO HAC VICE APPEARANCE by Jay Alan Sekulow. (Filing fee \$ 250 receipt number AIDDC-2436019.) Jay Alan Sekulow appearing for Amicus American Center for Law & Justice. Responses due by 9/6/2022 (Sekulow, Jay)
08/15/2022	34	MOTION FOR PRO HAC VICE APPEARANCE by Jordan A. Sekulow. (Filing fee \$ 250 receipt number AIDDC-2436031.) Jordan A. Sekulow appearing for Amicus American Center for Law & Justice. Responses due by 9/6/2022 (Sekulow, Jordan)
08/15/2022	35	MOTION FOR PRO HAC VICE APPEARANCE by Stuart J. Roth. (Filing fee \$ 250 receipt number AIDDC-2436050.)Stuart Roth appearing for Amicus American Center for Law & Justice. Responses due by 9/6/2022 (Roth, Stuart)
08/15/2022	<u>36</u>	MEMORANDUM/BRIEF filed by United States of America Regarding Live Testimony at August 22 Preliminary Injunction Hearing. (Schwei, Daniel)
08/15/2022	37	MOTION FOR PRO HAC VICE APPEARANCE by Olivia F. Summers. (Filing fee \$ 250 receipt number AIDDC-2436080.)Olivia F. Summers appearing for Amicus American Center for Law & Justice. Responses due by 9/6/2022 (Summers, Olivia)
08/15/2022	38	DOCKET ENTRY ORDER approving 32 Motion for Pro Hac Vice Appearance of attorney Laura Etlinger for California, State of,Laura Etlinger for Colorado, State of,Laura Etlinger for Connecticut, State of,Laura Etlinger for Delaware, State of,Laura Etlinger for Hawaii, State of,Laura Etlinger for Illinois, State of,Laura Etlinger for Maine, State of,Laura Etlinger for Maryland, State of,Laura Etlinger for Massachusetts, State of,Laura Etlinger for Michigan, State of,Laura Etlinger for Minnesota, State of,Laura Etlinger for New Jersey, State of,Laura Etlinger for New Mexico, State of,Laura Etlinger for New York, State of,Laura Etlinger for North Carolina, State of,Laura Etlinger for Oregon, State of,Laura Etlinger for Pennsylvania, State of,Laura Etlinger for Rhode Island, State of,Laura Etlinger for Washington DC,Laura Etlinger for Washington, State of Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/15/2022	39	MOTION for Leave to File <i>Brief as Amici Curiae</i> Wendy Olson appearing for Amicus The American Hospital Association and The Association of American Medical Colleges. 3-ER-410

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		Responses due by 9/6/2022 (Attachments: # 1 Exhibit Ex. A to Motion for Leave to File Brief of Amici Curiae)(Olson, Wendy) Modified on 8/16/2022 to change party filed name (alw).
08/15/2022	40	MOTION FOR PRO HAC VICE APPEARANCE by Amanda K. Rice. (Filing fee \$ 250 receipt number AIDDC-2436111.) Wendy Olson appearing for Amicus The American Hospital Association and The Association of American Medical Colleges. Responses due by 9/6/2022 (Olson, Wendy) Modified on 8/16/2022 to change filing party name (alw).
08/15/2022	41	DOCKET ENTRY ORDER approving 33 34 35 36 Motion for Pro Hac Vice Appearance of attorney Jay Alan Sekulow, Jordan A. Sekulow, Stuart Roth, Olivia F. Summers for American Center for Law & Justice Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/15/2022	42	MOTION FOR PRO HAC VICE APPEARANCE by Jacob M. Roth. (Filing fee \$ 250 receipt number AIDDC-2436117.) Wendy Olson appearing for Amicus The American Hospital Association and The Association of American Medical Colleges. Responses due by 9/6/2022 (Olson, Wendy) Modified on 8/16/2022 to change filing party name (alw).
08/15/2022	43	MOTION FOR PRO HAC VICE APPEARANCE by Charlotte H. Taylor. (Filing fee \$ 250 receipt number AIDDC-2436127.) Wendy Olson appearing for Amicus The American Hospital Association and The Association of American Medical Colleges. Responses due by 9/6/2022 (Olson, Wendy) Modified on 8/16/2022 to change filing party name (alw).
08/15/2022	44	MEMORANDUM/BRIEF filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature Regarding Live Testimony at August 22 Preliminary Injunction Hearing. (Bower, Daniel)
08/15/2022	45	MOTION to File Amicus Brief Laura Etlinger appearing for Amicus Parties California, State of, Colorado, State of, Connecticut, State of, Delaware, State of, Hawaii, State of, Illinois, State of, Maine, State of, Maryland, State of, Massachusetts, State of, Michigan, State of, Minnesota, State of, Nevada, State of, New Jersey, State of, New Mexico, State of, New York, State of, North Carolina, State of, Oregon, State of, Pennsylvania, State of, Rhode Island, State of, Washington DC, Washington, State of. Responses due by 9/6/2022 (Attachments: # 1 Memorandum in Support proposed amicus brief)(Etlinger, Laura)
08/15/2022	46	MEMORANDUM/BRIEF filed by State of Idaho re: letter brief requested by Dkt. 30. (Church, Brian)
08/15/2022	47	MOTION FOR ADMISSION PRO HAC VICE AND MOTION FOR WAIVER OF FEE by Shannon Rose Selden. Shannon Rose Selden appearing for Amicus Parties American College of Emergency Physicians, Idaho Chapter of the American College of Emergency Physicians, American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, National Medical Association, National Hispanic Medical Association, American Academy of Pediatrics, American Academy of Family Physicians, American Public Health Association, American Medical Association,. Responses due by 9/6/2022 (Selden, Shannon)
08/15/2022	48	MOTION FOR ADMISSION PRO HAC VICE AND MOTION FOR WAIVER OF FEE by Leah Martin. Leah S. Martin appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association, American Public Health Association, Idaho Chapter of the American
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		College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/6/2022 (Martin, Leah)
08/15/2022	49	MOTION FOR ADMISSION PRO HAC VICE AND MOTION FOR WAIVER OF FEE by Adam Aukland-Peck. Adam B. Aukland-Peck appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/6/2022 (Aukland-Peck, Adam)
08/15/2022	50	MOTION to File Amicus Brief (UNOPPOSED) Shannon Rose Selden appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/6/2022 (Attachments: # 1 Exhibit Brief of Amici Curiae in Support of Plaintiffs Motion for a Preliminary Injunction)(Selden, Shannon)
08/16/2022	51	ERRATA by Amicus Parties California, State of, Colorado, State of, Connecticut, State of, Delaware, State of, Hawaii, State of, Illinois, State of, Maine, State of, Maryland, State of, Massachusetts, State of, Michigan, State of, Minnesota, State of, Nevada, State of, New Jersey, State of, New Mexico, State of, New York, State of, North Carolina, State of, Oregon, State of, Pennsylvania, State of, Rhode Island, State of, Washington DC, Washington, State of re 45 MOTION to File Amicus Brief . (Attachments: # 1 Memorandum in Support corrected signature blocks on amicus brief and motion) (Etlinger, Laura)
08/16/2022	52	DOCKET ENTRY ORDER approving 40 42 43 Motion for Pro Hac Vice Appearance of attorney Amanda K Rice, Jacob M Roth, Charlotte H Taylor for The American Hospital Association, Amanda K Rice, Jacob M Roth, Charlotte H Taylor for The Association of American Medical Colleges Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/16/2022		CORRECTIVE ENTRY - The entry docket number 47 48 49 MOTION FOR ADMISSION PRO HAC VICE AND MOTION FOR WAIVER OF FEE by Shannon Rose Selden. filed by American Public Health Association, American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, American Academy of Family Physicians, National Hispanic Medical Association, American College of Emergency Physicians, National Medical Association, American Medical Association, American Academy of Pediatrics was filed incorrectly in this case. The filing parties shall re-submit their motions for pro hac and pay the filing fee.(alw)
08/16/2022	53	MOTION FOR PRO HAC VICE APPEARANCE by Shannon Rose Selden. (Filing fee \$ 250 receipt number AIDDC-2436424.)Shannon Rose Selden appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic 3-ER-412

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	 	Medical Association, National Medical Association, Society for Maternal-Fetal Medicine.
		Responses due by 9/6/2022 (Selden, Shannon)
08/16/2022	54	MOTION FOR PRO HAC VICE APPEARANCE by Leah Martin. (Filing fee \$ 250 receipt number AIDDC-2436438.)Leah S. Martin appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/6/2022 (Martin, Leah)
08/16/2022	55	MOTION FOR PRO HAC VICE APPEARANCE by Adam Aukland-Peck. (Filing fee \$ 250 receipt number AIDDC-2436445.) Adam B. Aukland-Peck appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/6/2022 (Aukland-Peck, Adam)
08/16/2022	56	DOCKET ENTRY ORDER: 39 The American Hospital Association and The Association of American Medical Colleges' Motion for Leave to File Brief as Amici Curiae is GRANTED. Amici are directed to formally file their [39-1] Proposed Brief. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)
08/16/2022	57	DOCKET ENTRY ORDER: 45 The States of California, New York, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, and Washington, and Washington, D.C.'s Motion to file Amicus Brief is GRANTED. Amici States are directed to formally file their Proposed Brief [45-1]. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)
08/16/2022	58	DOCKET ENTRY ORDER: 50 American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine's Motion to file Amicus Brief is GRANTED. Amici are directed to formally file their [50-1] Proposed Brief. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)
08/16/2022	59	RESPONSE to Motion re 17 MOTION for Preliminary Injunction filed by California, State of, Colorado, State of, Connecticut, State of, Delaware, State of, Hawaii, State of, Illinois, State of, Maine, State of, Maryland, State of, Massachusetts, State of, Michigan, State of, Minnesota, State of, Nevada, State of, New Jersey, State of, New Mexico, State of, New York, State of, North Carolina, State of, Oregon, State of, Pennsylvania, State of, Rhode Island, State of, Washington DC, Washington, State of. Replies due by 8/30/2022. (Etlinger, Laura)
08/16/2022	60	DOCKET ENTRY ORDER approving 53 54 55 Motion for Pro Hac Vice Appearance of attorney Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for American Academy of Family Physicians, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for American Academy of Pediatrics, Shannon Rose Selden, Leah S. Martin, Adam B. 3-ER-413

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		Aukland-Peck for American College of Emergency Physicians, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for American College of Obstetricians and Gynecologists, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for American Medical Association, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for American Public Health Association, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for Idaho Chapter of the American College of Emergency Physicians, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for National Hispanic Medical Association, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for National Medical Association, Shannon Rose Selden, Leah S. Martin, Adam B. Aukland-Peck for Society for Maternal-Fetal Medicine Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/16/2022	61	MOTION FOR PRO HAC VICE APPEARANCE by Laura B. Hernandez. (Filing fee \$ 250 receipt number AIDDC-2436596.)Laura Hernandez appearing for Amicus American Center for Law & Justice. Responses due by 9/6/2022 (Hernandez, Laura)
08/16/2022	62	RESPONSE to Motion re 17 MOTION for Preliminary Injunction filed by American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Replies due by 8/30/2022.(Selden, Shannon)
08/16/2022	63	RESPONSE re 17 MOTION for Preliminary Injunction filed by The American Hospital Association, The Association of American Medical Colleges /Amicus Brief re Docket 39. (Olson, Wendy)
08/16/2022	64	DOCKET ENTRY ORDER approving 61 Motion for Pro Hac Vice Appearance of attorney Laura Hernandez for American Center for Law & Justice Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/16/2022	65	MEMORANDUM in Opposition re 17 MOTION for Preliminary Injunction filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Replies due by 8/30/2022.(Bower, Daniel)
08/16/2022	66	RESPONSE to Motion re <u>17</u> MOTION for Preliminary Injunction filed by State of Idaho. Replies due by 8/30/2022. (Attachments: # <u>1</u> Declaration of Kraig White MD, # <u>2</u> Declaration of Randy Rodriguez)(Church, Brian)
08/17/2022	67	MOTION FOR PRO HAC VICE APPEARANCE by Jeffrey B. Dubner. (Filing fee \$ 250 receipt number AIDDC-2437111.) Jeffrey B. Dubner appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/7/2022 (Dubner, Jeffrey)
08/17/2022	<u>68</u>	MOTION FOR PRO HAC VICE APPEARANCE by John T. Lewis. (Filing fee \$ 250 receipt number AIDDC-2437139.) John Lewis appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of 3-ER-414

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		Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/7/2022 (Lewis, John)
08/17/2022	<u>69</u>	MOTION for Leave to File <i>LEGAL ARGUMENTS</i> Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 9/7/2022 (Attachments: # 1 Exhibit Legislatures unique legal arguments)(Bower, Daniel)
08/17/2022	70	DOCKET ENTRY ORDER approving 67 68 Motion for Pro Hac Vice Appearance of attorney John Lewis, Jeffrey B. Dubner for American Academy of Family Physicians, John Lewis, Jeffrey B. Dubner for American Academy of Pediatrics, John Lewis, Jeffrey B. Dubner for American College of Emergency Physicians, John Lewis, Jeffrey B. Dubner for American College of Obstetricians and Gynecologists, John Lewis, Jeffrey B. Dubner for American Medical Association, John Lewis, Jeffrey B. Dubner for Idaho Chapter of the American College of Emergency Physicians, John Lewis, Jeffrey B. Dubner for National Hispanic Medical Association, John Lewis, Jeffrey B. Dubner for National Medical Association, John Lewis, Jeffrey B. Dubner for National Medical Association, John Lewis, Jeffrey B. Dubner for Society for Maternal-Fetal Medicine Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/17/2022	71	AFFIDAVIT in Opposition re 17 MOTION for Preliminary Injunction filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Replies due by 8/31/2022. (Attachments: # 1 Affidavit Reynolds Declaration, # 2 Affidavit Harder Declaration, # 3 Exhibit Idaho Report of Induced Termination of Pregnancy, # 4 Exhibit Idaho Abortion Reporting Response, # 5 Affidavit French Declaration, # 6 Affidavit Loebs Declaration) (Bower, Daniel)
08/17/2022	<u>72</u>	NOTICE of Appearance by Alan Wayne Foutz on behalf of State of Idaho (Foutz, Alan)
08/17/2022	73	MEMORANDUM DECISION AND ORDER. Legislatures request for an evidentiary hearingis DENIED. Signed by Judge B Lynn Winmill. (alw)
08/17/2022	74	MOTION to File Amicus Brief Olivia F. Summers appearing for Amicus American Center for Law & Justice. Responses due by 9/7/2022 (Attachments: # 1 Memorandum in Support, # 2 Proposed Order)(Summers, Olivia)
08/17/2022	75	DOCKET ENTRY ORDER: Before the Court is the Idaho Legislature's Motion for Leave to File Legal Arguments 69. Having considered the Legislature's Motion, the Court declines at this juncture to modify the conditions it imposed in its earlier Order 27 allowing the Legislature to permissively intervene. Allowing the Legislature to file an additional brief past the deadline of the expedited briefing schedule would unduly prejudice the United States, which must file its reply brief by 12:00 pm MST, on August 19, 2022. In addition, the Legislatures total briefing would exceed not only the 15-page limit imposed by the Court but would also exceed the 20-page limit imposed by the Local Rules to which both the United States and the State of Idaho have adhered. IT IS THEREFORE ORDERED that the Legislature's Motion for Leave to File Legal Arguments 69 is DENIED. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)

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08/17/2022	76	DOCKET ENTRY ORDER: The American Center for Law & Justice's 74 Motion for Leave to file Amicus Brief in Support of Defendant's Response to Plaintiff's Motion for Preliminary Injunction is GRANTED. The ACLJ is directed to formally file its [74-1] Proposed Brief. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)
08/17/2022	77	MOTION for Extension of Time to File Answer <i>or Otherwise Respond (unopposed)</i> Brian V Church appearing for Defendant State of Idaho. Responses due by 9/7/2022 (Attachments: # 1 Memorandum in Support)(Church, Brian)
08/17/2022	78	DOCKET ENTRY ORDER GRANTING Motion for Extension of Time to Answer or Otherwise Respond (Dkt. 77). The State of Idaho shall answer or other respond by September 23, 2022. Signed by Judge B Lynn Winmill. (hgp)
08/18/2022	<u>79</u>	Minute Entry for proceedings held before Judge B Lynn Winmill: An informal Video Status Conference was held on 8/18/2022. (Court Reporter/ESR Not recorded.) Hearing Not Recorded. (jlg)
08/18/2022	80	MEMORANDUM/BRIEF re 76 Order on Motion to File Amicus Brief, <u>74</u> MOTION to File Amicus Brief filed by American Center for Law & Justice <i>Amicus Brief in Support of Defendant's Response</i> . (Summers, Olivia)
08/18/2022	81	MOTION FOR PRO HAC VICE APPEARANCE by Thomas M. Fisher. (Filing fee \$ 250 receipt number AIDDC-2437960.)Thomas Molnar Fisher appearing for Amicus State of Indiana. Responses due by 9/8/2022 (Fisher, Thomas)
08/19/2022	82	MOTION FOR PRO HAC VICE APPEARANCE by Maher Mahmood. (Filing fee \$ 250 receipt number AIDDC-2438637.) Maher Mahmood appearing for Amicus Parties American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Medical Association,, American Public Health Association, Idaho Chapter of the American College of Emergency Physicians, National Hispanic Medical Association, National Medical Association, Society for Maternal-Fetal Medicine. Responses due by 9/9/2022 (Mahmood, Maher)
08/19/2022	83	DOCKET ENTRY ORDER approving 81 Motion for Pro Hac Vice Appearance of attorney Thomas Molnar Fisher for State of Indiana Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/19/2022	84	DOCKET ENTRY ORDER approving 82 Motion for Pro Hac Vice Appearance of attorney Maher Mahmood for American Academy of Family Physicians, Maher Mahmood for American College of Emergency Physicians, Maher Mahmood for American College of Obstetricians and Gynecologists, Maher Mahmood for American Medical Association, Maher Mahmood for American Public Health Association, Maher Mahmood for Idaho Chapter of the American College of Emergency Physicians, Maher Mahmood for National Hispanic Medical Association, Maher Mahmood for National Medical Association, Maher Mahmood for Society for Maternal-Fetal Medicine Per Local Rule 83.4(e), out-of-state counsel shall immediately register for ECF. (Notice sent to CM/ECF Registration Clerk) (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (alw)
08/19/2022	85	AMENDED DOCUMENT by State of Indiana. Application for Admission Pro Hac Vice on behalf of States of Indiana, Alabama, Arkansas, Kentucky, Louisiana, Mississippi,
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		Montana, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming. (Fisher, Thomas)
08/19/2022	86	REPLY to Response to Motion re 17 MOTION for Preliminary Injunction filed by United States of America. Motion Ripe Deadline set for 8/22/2022. (Attachments: # 1 Exhibit List, # 2 Ex. H, Supplemental Fleisher Declaration, # 3 Ex. I, Supplemental Corrigan Declaration, # 4 Ex. J, Huntsberger Declaration, # 5 Ex. K, Supplemental Cooper Declaration, # 6 Ex. L)(Newman, Lisa)
08/19/2022	87	MOTION for Leave to File <i>Brief of Indiana and 16 Other States as Amici Curiae in Support of Defendant</i> Thomas Molnar Fisher appearing for Amicus State of Indiana. Responses due by 9/9/2022 (Attachments: # 1 Exhibit Text of Proposed Order, # 2 Memorandum in Support)(Fisher, Thomas)
08/19/2022	88	DOCKET ENTRY NOTICE OF HEARING regarding 17 MOTION for Preliminary Injunction: A Motion Hearing is set for 8/22/2022 at 9:00 AM in Boise - Courtroom 2 before Judge B Lynn Winmill. Members of the public may attend the hearing remotely. Remote access will be audio only - there will not be video. To access an audio feed from the hearing, members of the public may call this number: 208-684-0990. Then, when they are prompted for the conference ID, they should enter 238 965 497#.(jlg)
08/19/2022	89	DOCKET ENTRY ORDER: <u>87</u> Unopposed Motion for Leave to File Brief of Indiana and 16 Other States as Amici Curiae in Support of Defendant is GRANTED. Amici are directed to file their [87-2] Proposed Brief. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)
08/19/2022	90	MEMORANDUM/BRIEF re 89 Order on Motion for Leave to File, filed by State of Alabama, State of Arkansas, State of Indiana, State of Kentucky, State of Louisiana, State of Mississippi, State of Montana, State of North Dakota, State of Oklahoma, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah, State of West Virginia, State of Wyoming, State of Nebraska. (Fisher, Thomas) Modified on 8/25/2022 to add party (alw).
08/19/2022	91	NOTICE by State of Idaho <i>Notice of Appearance Special Deputy Attorney General Clay R. Smith</i> (Church, Brian)
08/22/2022	92	Minute Entry for proceedings held before Judge B Lynn Winmill: A Motion Hearing was held on 8/22/2022 re 17 MOTION for Preliminary Injunction filed by United States of America. A written decision is forthcoming. (Court Reporter Tammy Hohenleitner.) (jlg)
08/22/2022	93	RESPONSE filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature <i>Objection to Proposed Order [Dkt. 17-2]</i> . (Attachments: # 1 Exhibit 1 Proposed Fall-Back Order - redline, # 2 Exhibit 2 Proposed Fall-Back Order - clean, # 3 Exhibit 3 EMTALA)(Bower, Daniel)
08/24/2022	94	NOTICE by State of Idaho <i>of Supplemental Authority</i> (Attachments: # 1 Exhibit Exhibit A - U.S. District Court for Northern District of Texas Decision)(Church, Brian)
08/24/2022	95	MEMORANDUM DECISION AND ORDER. IT IS ORDERED that: Plaintiff's motion for a preliminary injunction (Dkt. 17) is GRANTED. This preliminary injunction is effective immediately and shall remain in full force and effect through the date on which judgment is entered in this case. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (km)

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08/25/2022	96	Notice of Filing of Official Transcript of Proceedings held on 8/22/22 before Judge B. Lynn Winmill. Court Reporter Tamara Hohenleitner, Email tammy_hohenleitner@id.uscourts.gov. Transcript may be viewed at the court public terminal or purchased through the Court Reporter before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. This transcript is not available to the general public and as such is sealed until release of transcript restriction re 92 Motion Hearing. Redaction Request due 9/15/2022. Redacted Transcript Deadline set for 9/26/2022. Release of Transcript Restriction set for 11/23/2022. (th)
09/07/2022	97	MOTION for Reconsideration re <u>95</u> Order on Motion for Preliminary Injunction, Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 9/28/2022 (Attachments: # <u>1</u> Memorandum in Support)(Bower, Daniel)
09/15/2022	98	NOTICE by United States of America of Factual Clarification (Attachments: # 1 Affidavit of Dr. Fleisher (Second Supplemental))(Schwei, Daniel)
09/15/2022	99	MOTION for Extension of Time to File Response/Reply as to <u>97</u> MOTION for Reconsideration re <u>95</u> Order on Motion for Preliminary Injunction, Christopher A. Eiswerth appearing for Plaintiff United States of America. Responses due by 10/6/2022 (Attachments: # <u>1</u> Exhibit A Correspondence)(Eiswerth, Christopher)
09/16/2022	100	RESPONSE to Motion re 99 MOTION for Extension of Time to File Response/Reply as to 97 MOTION for Reconsideration re 95 Order on Motion for Preliminary Injunction, <i>Partial Non-Opposition</i> filed by State of Idaho. Replies due by 9/30/2022.(Church, Brian)
09/21/2022	101	MOTION for Reconsideration Brian V Church appearing for Defendant State of Idaho. Responses due by 10/12/2022 (Attachments: # 1 Memorandum in Support of State of Idaho's Motion to Reconsider)(Church, Brian)
09/22/2022	102	ORDER. Upon consideration of the United States Motion to Extend Briefing Schedule Regarding Motions for Reconsideration, and finding good cause, IT IS ORDERED that the United States motion is GRANTED. Signed by Judge B Lynn Winmill. (alw)
09/23/2022	103	ANSWER to 1 Complaint, by State of Idaho.(Church, Brian)
09/28/2022	104	RESPONSE to Motion re <u>97</u> MOTION for Reconsideration re <u>95</u> Order on Motion for Preliminary Injunction, (Non-Opposition) filed by State of Idaho. Replies due by 10/12/2022.(Church, Brian)
10/04/2022	105	MOTION to Intervene Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 10/25/2022 (Attachments: # 1 Memorandum in Support of Renewed Motion to Intervene)(Bower, Daniel)
10/05/2022		The 60 day deadline has expired. Case will remain with a District Judge. No more notice of availability or assignment will be sent out. Consent deadline(s) termed. (alw)
10/12/2022	106	MEMORANDUM in Opposition re 101 MOTION for Reconsideration, 97 MOTION for Reconsideration re 95 Order on Motion for Preliminary Injunction, filed by United States of America. Replies due by 10/26/2022.(Eiswerth, Christopher)
10/19/2022	107	Joint MOTION modification of briefing schedule of Idaho Legislatures Renewed Motion to Intervene re 105 MOTION to Intervene Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate 3-ER-418

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	1	due by 11/9/2022 (Attachments: # 1 Exhibit)(Bower, Daniel)
10/20/2022	108	DOCKET ENTRY ORDER granting 107 Motion. Good cause appearing, the briefing schedule on the Legislature's Renewed Motion to Intervene (Dkt. 105) is modified as follows: Responses shall be filed by October 20, 2022. The optional reply brief shall be filed by October 27, 2022. Signed by Judge B. Lynn Winmill. (caused to be mailed to nor Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (mls))
10/20/2022	109	MEMORANDUM in Opposition re 105 MOTION to Intervene filed by United States of America. Replies due by 11/3/2022.(Deffebach, Anna)
10/20/2022	110	RESPONSE to Motion re 105 MOTION to Intervene filed by State of Idaho. Replies due by 11/3/2022.(Olsen, Steven)
10/26/2022	111	REPLY to Response to Motion re <u>97</u> MOTION for Reconsideration re <u>95</u> Order on Motion for Preliminary Injunction, filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature.Motion Ripe Deadline set for 10/27/2022.(Bower, Daniel)
10/26/2022	112	REPLY to Response to Motion re 101 MOTION for Reconsideration filed by State of Idaho.Motion Ripe Deadline set for 10/27/2022.(Church, Brian)
10/27/2022	113	REPLY to Response to Motion re 105 MOTION to Intervene filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature.Motion Ripe Deadline set for 10/28/2022. (Bower, Daniel)
10/28/2022	114	NOTICE by State of Idaho of Withdrawal of Counsel (Larrondo, Megan)
11/17/2022	115	NOTICE by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature re 97 MOTION for Reconsideration re 95 Order on Motion for Preliminary Injunction, , 105 MOTION to Intervene (Bower, Daniel)
12/13/2022	<u>116</u>	NOTICE by State of Idaho of Withdrawal of Counsel (Reed, Dayton)
12/14/2022	117	NOTICE by State of Idaho of Withdrawal of Counsel (Batey, Ingrid)
12/30/2022	118	NOTICE by State of Idaho of withdrawal of Special Deputy Attorney General Clay R. Smith (Church, Brian)
01/13/2023	119	MOTION Permission to File Supplemental Briefing and Notice of Supplemental Authority Brian V Church appearing for Defendant State of Idaho. Responses due by 2/3/2023 (Attachments: # 1 Memorandum in Support of Request for Permission to File Supplemental Briefing, # 2 Planned Parenthood Decision)(Church, Brian)
01/13/2023	120	MOTION to Stay <i>Issuance of a Decision</i> Brian V Church appearing for Defendant State of Idaho. Responses due by 2/3/2023 (Attachments: # 1 Memorandum in Support of Motion to Stay Issuance of a Decision)(Church, Brian)
01/13/2023	121	JOINDER by Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature joining 119 MOTION Permission to File Supplemental Briefing and Notice of Supplemental Authority, 120 MOTION to Stay Issuance of a Decision . (Attachments: # 1 Exhibit 1 Planned Parenthood Decision)(Bower, Daniel)
01/13/2023		NOTICE TO COURT that counsel Dayton Reed wishes to no longer be noticed

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		electronically on this case as of the date of this notice. (Reed, Dayton)			
01/24/2023	122	DOCKET ENTRY ORDER granting 119 State of Idaho's Motion for Permission to File Supplemental Briefing on the State's pending motion for reconsideration 101. The State of Idaho may file a supplement brief in support of its motion for reconsideration not to exceed 10 pages no later than February 6, 2023. As the Idaho Legislature has joined in the motion, it may also file a separate brief in support of its motion for reconsideration not to exceed 10 pages by February 6, 2023. In response, the United States of America may file two briefs responding to each supplemental brief filed by the State and the Legislature not to exceed ten pages each, or one omnibus response brief not to exceed 20 pages by February 21, 2023. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)			
01/24/2023	123	DOCKET ENTRY ORDER: IT IS ORDERED that 120 the State of Idaho's Motion to Stay Issuance of a Decision is GRANTED. The Court will not issue a decision on the pending motions to reconsider until the supplemental briefing has been completed on February 21, 2023, and the Court has had adequate time to consider the additional argument. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)			
01/24/2023	124	NOTICE by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature of Automatic Substitution of Certain Intervenor-Defendants (Bower, Daniel)			
02/03/2023	125	MEMORANDUM DECISION AND ORDER. Idaho Legislatures Renewed Motion to Intervene (Dkt. <u>105</u> ) is DENIED. Signed by Judge B Lynn Winmill. (alw)			
02/06/2023	126	MEMORANDUM in Support re <u>97</u> MOTION for Reconsideration re <u>95</u> Order on Motion for Preliminary Injunction, filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. (Attachments: # <u>1</u> Exhibit 1)(Bower, Daniel)			
02/06/2023	127	SUPPLEMENT by Defendant State of Idaho Supplemental Brief Supporting State of Idaho's Motion for Reconsideration. (Olsen, Steven)			
02/06/2023	128	MOTION to Take Judicial Notice Steven Lamar Olsen appearing for Defendant State of Idaho. Responses due by 2/27/2023 (Attachments: # 1 Exhibit 1)(Olsen, Steven)			
02/21/2023	129	NOTICE of Appearance by Lincoln Davis Wilson on behalf of State of Idaho (Wilson, Lincoln)			
02/21/2023	130	SUPPLEMENT by Plaintiff United States of America re 101 MOTION for Reconsideration, 97 MOTION for Reconsideration re 95 Order on Motion for Preliminary Injunction, <i>United States' Supplemental Brief in Opposition to the Motions for Reconsideration</i> . (Deffebach, Anna)			
03/02/2023	131	NOTICE OF APPEAL as to 125 Memorandum Decision, Terminate Motions by Speake of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Filing Fee Paid. \$ 505, receipt number AIDDC-2530532. (Notice sent to Court Reporter & 9th Cir) (Bower, Daniel)			
03/03/2023	132	USCA Case Number 23-35153 for 131 Notice of Appeal, filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. (alw)			
03/03/2023	133	USCA Scheduling Order 23-35153 as to 131 Notice of Appeal, filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck			
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,	Case.	23-35440, 06/07/2023, ID. 12769991, DKIEIIIIY. 13-4, Page 291 01 292			
		Winder, and the Sixty-Sixth Idaho Legislature. (Notice sent by e-mail to Court Reporter) (alw)			
05/04/2023	134	DOCKET ENTRY ORDER granting 128 the State of Idaho's Request to Take Judicial Notice, under Federal Rule of Evidence 201, that the Idaho Supreme Courts Planned Parenthood decision released January 5, 2023, Dkt. 119-2, is now final. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)			
05/04/2023	135	MEMORANDUM DECISION AND ORDER. IT IS ORDERED that: (1) the Idaho Legislatures Motion for Reconsideration of Order Granting Preliminary Injunction (Dkt. 97) is DENIED; and (2) the State of Idahos Motion to Reconsider Preliminary Injunction (Dkt. 101) is DENIED. Signed by Judge B Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (jsv)			
06/28/2023	136	NOTICE OF APPEAL (USCA 23-35440) as to 95 Order on Motion for Preliminary Injunction, 135 Order on Motion for Reconsideration,,, by State of Idaho. Filing Fee Duc \$505, receipt number AIDDC-2590508. (Notice sent to Court Reporter & 9th Cir) (Wilson, Lincoln) Modified on 6/29/2023 to add 9CCA case number (hs).			
06/28/2023	137	USCA Case Number 23-35440 for <u>136</u> Notice of Appeal, filed by State of Idaho. (hs) (Entered: 06/29/2023)			
07/03/2023	138	NOTICE OF APPEAL (23-35450) by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Filing Fee Due. \$ 505, receipt number AIDDC-2592636. (Notice sent to Court Reporter & 9th Cir) (Bower, Daniel) Modified on 7/5/2023 to add 9CCA Case Number (km).			
07/03/2023	139	TRANSCRIPT REQUEST by State of Idaho for proceedings held on 8/22/2022 before Judge Winmill, (Notice sent by e-mail to Court Reporter) (Church, Brian)			
07/03/2023	140	MOTION to Stay <i>Preliminary Injunction Pending Appeal</i> Daniel W. Bower appearing for Intervenor Defendant Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. Responses due by 7/24/2023 (Attachments: # 1 Memorandum in Support Legislature's Memo ISO Stay)(Bower, Daniel)			
07/03/2023	141	USCA Case Number 23-35450 for <u>138</u> Notice of Appeal, filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature. (km) (Additional attachment(s) added or 7/5/2023: # 1 Notice to Review Party and Counsel Listing, # 2 Mediation Letter) (km). (Entered: 07/05/2023)			
07/05/2023	142	TRANSCRIPT REQUEST by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature for proceedings held on 08/22/2022 before Judge Winmill, (Notice sent by e mail to Court Reporter) (Bower, Daniel)			
07/06/2023	143	NOTICE by State of Idaho of Withdrawal of Counsel (Callahan, Joan)			
07/24/2023	144	MEMORANDUM in Opposition re 140 MOTION to Stay <i>Preliminary Injunction Pending Appeal</i> filed by United States of America. Replies due by 8/7/2023. (Attachments: # 1 Exhibit Exhibit A)(Deffebach, Anna)			
08/04/2023	145	REPLY to Response to Motion re 140 MOTION to Stay <i>Preliminary Injunction Pending Appeal</i> filed by Speaker of the Idaho House of Representatives Scott Bedke, Idaho Senate			
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President Pro Tempore Chuck Winder, and the Sixty-Sixth Idaho Legislature.Motion Ripe Deadline set for 8/7/2023.(Bower, Daniel)

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