

EMTALA IN A POST-*DOBBS* WORLD: THE MARCH TOWARDS FETAL PERSONHOOD CONTINUES

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For decades, people in medical distress were able to rely on a federal law, known as EMTALA, which requires medical screenings and stabilizing treatment in hospital emergency rooms regardless of medical or financial circumstances. For some presenting pregnant patients, the standard of care stabilizing medical treatment included abortion care. In June 2022, the U.S. Supreme Court issued its decision in *Dobbs v. Jackson Women’s Health Organization*, overturning *Roe v. Wade*, and moving the question of abortion care to the states. In the aftermath of the *Dobbs* decision, as states pursue individual paths, the interplay between federal law and state law is increasingly becoming the subject of litigation and of scholarship. One of the more notable areas in which state law and federal preemption are clashing is over EMTALA and reproductive health care. Specifically, as to whether patients presenting at EMTALA-covered emergency departments whose medical screening reveals a condition for which abortion is the stabilizing treatment called for are still entitled to that care in states that have severely curtailed or banned abortions. Two states (Idaho and Texas) currently have active lawsuits addressing this question: the correct interplay between EMTALA’s requirements and abortion restrictive state laws. As of this writing, the two lawsuits have reached different, if preliminary, conclusions. The Idaho federal district court opinion focused on the rights and medical needs of pregnant people presenting at emergency departments, to reach its conclusion that Idaho emergency departments must continue to follow EMTALA’s mandates. The Texas court opinion found that EMTALA protects both pregnant people and unborn children equally and

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that the state's anti-abortion laws provided a legally defensible solution to this conflict, leading to its holding that Texas emergency rooms can follow that state's anti-abortion laws without running afoul of EMTALA.

In this article, I first focus on EMTALA itself, setting out the history of mandated private hospital emergency care, the impetus behind this federal statute, its requirements and penalties, and how it impacts reproductive health care. I then explain the Supreme Court's June 2022 decision in *Dobbs* and lay out the anti-abortion laws in both Idaho and Texas when this decision was issued. After describing the state-level landscape post-*Dobbs*, I address the federal government's response to the decision in relation to EMTALA. I next explain the origins of the two lawsuits testing the supremacy of EMTALA in Idaho and Texas and the conflicting preliminary injunction holdings on emergency room treatment related to abortion care. This article highlights how these differing decisions turn on an understanding of who the patient in need of emergency medical care actually is, with the Texas court essentially awarding personhood status to the fetus that is equal to that of the pregnant patient, and the Idaho court properly focusing on the health of the pregnant person. After providing a history of the fetal personhood movement in this country, I make the argument that according equal rights to the fetus under EMTALA is both an erroneous reading of that statute and an immoral assault on the bodily autonomy of the pregnant person. I argue that the decision in the Texas EMTALA case is a dangerous harbinger not just to federal supremacy and to abortion care but to a range of additional rights. My argument focuses on the fact that while abortion is an important aspect of health care, it is one moment in time—a legal recognition of fetal personhood would mean that from conception to birth the pregnant person's value as an autonomous human is effectively undermined. The article concludes by providing a window into how this conflict may continue to play out in the future.

I. THE HISTORY BEHIND EMTALA

Historically, private hospitals in America generally had no specific legal duty to treat everyone who presented at their facility.¹ This maxim was upheld by courts across the country, which found, in a variety of circumstances, that non-admitted patients had no right to demand treatment.² In other words, if treatment had not yet begun, anyone could be turned away from a hospital emergency room. Private hospitals generally refused treatment, or transferred patients to public hospitals, for one of two reasons. First, they did so to avoid the high mortality rates that came

1. See Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 *Hous. L. Rev.* 21, 21 (Jan. 1, 1989) (examining the evolution of the idea that hospitals had such a legal duty).

2. See, e.g., *Hill v. Ohio Cnty.*, 468 S.W.2d 306, 309 (Ky. 1970) (holding that a public hospital has no duty to admit a pregnant woman about to give birth); *Birmingham Baptist Hosp. v. Crews*, 157 So. 224, 225 (Ala. 1934) (“[d]efendant is a private corporation . . . and owes the public no duty to accept any patient not desired by it.”).

from admitting seriously injured or ill patients.³ Hospitals wanted to suppress the long-standing reputation that they were places people came to die, and high mortality rates fed that impression and kept patients, particularly paying ones, away.⁴ Second, hospitals often refused to provide care when a presenting patient, even one without an immediate life-threatening illness, could not pay the fees demanded.⁵ Initial efforts to challenge refusals by private hospitals to provide medical treatment were stymied by several factors, including a legal distinction between allowable non-treatment of a patient and unallowable mistreatment of a patient, and by the protective doctrine of charitable immunity.⁶

As hospitals stopped publicizing their mortality rates, the primary reason for continued refusals to provide care was a patient's insufficient financial ability, and legislators and the public began to take notice and issue with this practice. In the twentieth century, the phrase "patient dumping" was resurrected and has come to represent the practice of refusing medical care because of the sick or injured person's inability to pay.⁷ Efforts to combat patient dumping included proposed state legislative fixes, municipal ordinances, internal revenue code obligations, antidiscrimination statutes, and calls for ethical decision-making—all efforts that were met with limited success.⁸ Widespread outrage over the practice of patient dumping continued to grow, fueled by individual stories of denied care.⁹ In 1946, Congress enacted the Hill-Burton Act, which provided federal funding for hospital construction and maintenance in exchange for, *inter alia*, a requirement that hospitals provide a "reasonable volume" of uncompensated care for two decades.¹⁰ Like the efforts preceding it, the Hill-Burton Act did not meet its goal; citizens remained unable to pay for and access emergency medical care, and private

3. Emily Abel, Patient Dumping in New York City, 1877–1917, 101 AM. J. PUB. HEALTH, 789, 789 (2011).

4. *Id.*

5. See, e.g., *Le Juene Road. Hosp., Inc. v. Watson*, 171 So. 2d 202, 205 (Fla. Dist. Ct. App. 1965) (finding that the hospital had a mother leave with her minor son prior to having his scheduled operation because of her inability to pay \$200 in cash).

6. Rothenberg, *supra* note 1, at 25–29.

7. See Abel, *supra* note 3. The *New York Times* is credited with coining the term "patient dumping" in the nineteenth century, in a series of articles describing how private hospitals in New York were 'dumping' indigent patients at the city's public hospital, regardless of the deleterious effect this had on the patient. *Id.*

8. Jay C. Weaver, *Emergency Medicine Specialty Reports - EMTALA Update: Current Practice and Future Impact*, EMERGENCY MED. REPS. (Mar. 23, 2003) (noting that the IRS and nineteen states had statutorily imposed emergency room obligations for hospitals, but these were rarely enforced); see also Abel, *supra* note 3.

9. David A. Hyman, *Lies, Damned Lies and Narrative*, 73 IND. L. J. 797, 800–10 (1998) (examining the impact of individual stories in legislative action, and in the passage of EMTALA).

10. Hill-Burton Act, 42 U.S.C. § 291.

hospitals continued patient dumping.¹¹ Two decades later, in a further effort to address this ongoing crisis, and overcoming staunch opposition, then President Lyndon B. Johnson signed the Social Security Amendments of 1965, which enacted the federal Medicaid and Medicare programs, so that indigent and elderly people could access medical care.¹² Despite these gains, reliably accessible health care, including the ability to access medical care in a crisis, remained inconsistent.¹³ Practically, this meant that from common law until well into the twentieth century, no person presenting at a private hospital was assured of treatment.¹⁴

While the practice of patient dumping had never fully gone away even after the creation of the Medicare and Medicaid programs, it increased in frequency in the late 1970s and early 1980s as hospitals sought to limit expenditures at the same time that medical costs were spiraling and as increasing numbers of uninsured and indigent people sought care.¹⁵ Thus, despite all the prior efforts to increase emergency medical access, the 1980s saw a spike in the number of care denials in private hospitals.¹⁶ Publicized accounts of patients, primarily pregnant persons and low-income black, indigenous, and other people of color, dying in one of the world's richest countries because private hospitals refused to treat them or transferred them without stabilizing their condition refueled efforts to curb the practice.¹⁷

11. *Patient Dumping*, U.S. COMM'N ON CIVIL RIGHTS 1, 4–5 (Sept. 2014), https://www.usccr.gov/files/pubs/docs/2014PATDUMPOSD_9282014-1.pdf (noting that, among other issues, Hill-Burton did not define the word 'emergency,' did not have accompanying regulations, and suffered from a lack of enforcement, and noting that the Act was only meant as an initial effort).

12. *Milestone Documents: Medicare and Medicaid (1965)*, NAT'L ARCHIVES (Feb. 8, 2022), <https://www.archives.gov/milestone-documents/medicare-and-medicare-act>; see also Julian Zelizer, *How Medicare Was Made*, THE NEW YORKER (Feb. 15, 2015), <https://www.newyorker.com/news/news-desk/medicare-made>.

13. Jeffrey E. Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 J. URB. & CONTEMP. L., 123, 123–25 (1983) (noting that people cannot always access emergency care in years after 1965).

14. Rothenberg, *supra* note 1.

15. Thomas L. Stricker Jr., *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121, 1123–26 (1992) (noting the limited success of pre-EMTALA efforts to curb patient dumping).

16. U.S. Comm'n on Civ. Rights, *supra* note 11, at 4 (citing H.R. Rep. No. 100-531, at 3–4 (1988)). Note that federal expenditures for Medicaid were also being significantly decreased during the early 1980s. Shaun Ossei-Owusu, *The State Giveth and Taketh Away: Race, Class, and Urban Hospital Closings*, 92 CHI. KENT L. REV. 1037, 1045 (2017).

17. Robert L. Schiff et al., *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 522, 555 (1986) (finding that over 80% of the patients transferred in a prospective study were Black or Hispanic, almost 90% were uninsured, many were unstable, and their mortality rate was higher than expected); see also Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 147–48 (2004).

II. THE REQUIREMENTS OF EMTALA

As the reports of continued patient dumping, despite the actions taken to curb the practice, began to climb, it became clear to many legislators that a workable solution to the issue had not yet been found.¹⁸ Witnesses testifying at a Congressional hearing held on patient dumping further convinced legislators that the practice remained a problem.¹⁹ It was out of this history that Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which was signed into law by then President Ronald Reagan.²⁰ Under EMTALA, any hospitals receiving Medicare funding (which for practical purposes means all hospitals) must screen any patient that presents at an emergency department to see if an emergency medical condition exists.²¹ Emergency departments include labor and delivery departments if they provide emergency labor and delivery services.²² If any emergency medical condition is found during the required screening, the emergency department must stabilize that patient before discharging or appropriately transferring them.²³ The hospital may also admit them, in good faith,

18. The Congressional legislative history shows an awareness of the continued problem: The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital. H.R. Rep. No. 99-241, at 27 (1986).

19. Equal Access to Health Care: Patient Dumping. Hearing Before a House Subcommittee of the Committee on Government Operations, 100th Cong. (1987), <https://files.eric.ed.gov/fulltext/ED297237.pdf>.

20. Emergency Medical Treatment and Active Delivery Act, 42 U.S.C. § 1395dd (2020). Note that EMTALA has been since amended multiple times by Congress.

21. 42 U.S.C. § 1395dd(a).

22. Clarification of “Comes to the Emergency Department”, 68 Fed. Reg. 53,228 (Sept. 9, 2003); see also Friedrich v. S. Cnty. Hosp. Healthcare Sys., 221 F. Supp. 3d 240, 242–44 (D.R.I. 2016) (discussing the attributes of an emergency department).

23. Note that the understanding of “when” a “patient comes to the emergency room” has expanded over time and now includes patients on a hospital campus, which includes up to 250 yards from the main hospital building as well as at other crisis centers such as labor and delivery. One case held that a patient must physically “come to” an emergency department before EMTALA obligations are triggered—a phone call or similar request are not sufficient. *Miller v. Med. Ctr. of Sw. La.*, 22 F.3d 626, 628–29 (5th Cir. 1994). Another case held that EMTALA is not triggered by a hospital operated telemetry system that responds to a patient call. *Johnson v. Univ. of Chi. Hosps.*, 982 F.2d 230, 233 (7th Cir. 1992). See also Joseph Zibulewsky, MD, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What it is and What it Means for Physicians*, 14 BAYLOR UNIV. MED. CTR. PROCS. 339, 339 (2001).

in order to stabilize them.²⁴ Stabilizing a patient means that the facility has provided the medical care necessary “to assure, within reasonable medical possibility, that no material deterioration of the condition is likely to result from or occur during the transfer[.]”²⁵ An “appropriate” transfer is one that occurs only after minimizing the risk of the movement to the patient’s condition and only to a suitable facility that has agreed to accept the patient before transport is underway.²⁶

Under EMTALA, an “emergency medical condition” does not mean the patient must be in a life-or-death state to receive medical care; rather, it means that a lack of medical attention could result in serious impairment or dysfunction.²⁷ And, because reports of care refusals in pregnancy related emergencies were of particular concern, pregnant people in labor are the only sub-population targeted by name in the statute. Specifically, EMTALA’s definition of an emergency medical condition reads as follows:

(1) The term “emergency medical condition” means--

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

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

(ii) serious impairment to bodily functions, or

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

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

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

24. 42 C.F.R. § 489.24(d)(2)(i) (2023).

25. 42 U.S.C. § 1395dd(e)(3)(A) (2020).

26. Hospitals can be held liable for improper transport regardless of any proof of the motive behind that transfer. *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 250 (1999).

27. Al Lulla & Bridgette Svancarek, *EMS USA Emergency Medical Treatment and Active Labor Act*, NIH NAT’L LIBR. OF MED., <https://www.ncbi.nlm.nih.gov/books/NBK539798/> (Oct. 17, 2022).

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.²⁸

As one example in the abortion health care context, this language means that if a pregnant person presents at an EMTALA-covered emergency department in severe pain, the department must screen them. And if that screening reveals a condition that, left untreated, could (for example) put their future reproductive function in risk, that pregnant person has presented with an emergency medical condition requiring immediate care. If the standard of care in that hypothetical situation is an abortion, EMTALA mandates that care at that hospital.²⁹ EMTALA covered emergency departments could not leave that pregnant person to decompensate, send them home, or transfer them to another facility to avoid providing care.³⁰

Although each state can pass many of its own laws regarding the provision of health care, EMTALA specifically preempts any state or local laws in direct conflict and covers everyone who enters a covered emergency room regardless of their membership in a protected class. The statute states, “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.”³¹ In essence, hospitals voluntarily agree to the requirements of EMTALA by their acceptance of federal Medicare dollars. If a hospital does not want to comply with EMTALA’s requirements, they can refuse the federal funding that compels such compliance.³² While hospitals accepting these federal dollars must screen, stabilize and/or transfer all patients that come to their facility, EMTALA is not meant to do more

28. 42 U.S.C. § 1395dd(e)(1) (2020). Note that pregnant people in labor is a distinguishable medical category from pregnant people experiencing pregnancy complications.

29. Note that EMTALA does not exclude any categories of patients or any course of treatment. Instead, the history of EMTALA and the cases decided pre-*Dobbs* all stand for the proposition that Congress wanted the statute interpreted as broadly as possible and that all patients would be treated with the same standard of care. In other words, if a particular state or locality determined that a course of treatment or a type of patient would be treated differently because of a law and not because of medicine, that decision could not hold in a facility that accepted Medicare funding. See generally Mary Jean Fell, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Discrimination in Access to Emergency Medical Care*, 43 CATH. UNIV. L. REV. 607 (1994).

30. Note that patients can request or refuse transfer. EMTALA 42 U.S.C. § 1395dd(b)–(c).

31. 42 U.S.C. § 1395dd(f).

32. *Lima-Rivera v. UHS of Puerto Rico, Inc.*, 476 F. Supp. 2d 92, 98 (D.P.R. 2007) (“To establish an EMTALA violation, a plaintiff must show that (1) the hospital is a participating hospital, covered by EMTALA . . .”).

than that.³³ Under EMTALA presenting patients are entitled to screenings meant to identify emergency conditions as defined by the statute, which means screenings that are consistent with those received by other similarly situated patients.³⁴ Because of this limited purpose, numerous courts have held that EMTALA is distinct from any malpractice claims.³⁵ However, while courts agree that EMTALA entitles presenting patients to an appropriate medical screening, the difference between an appropriate EMTALA screening and an inappropriate EMTALA screening is a line often difficult to parse,³⁶ and courts have generally determined that standard of care screenings that are largely consistent between patients suffice.³⁷ Additionally, EMTALA covers emergency rooms only. This means that a medical facility without an emergency department is not subject to EMTALA, provided it clearly does not provide any emergency care.³⁸ It also means that once a patient is admitted to a hospital, even one with an emergency department, EMTALA no longer applies.³⁹

33. *Frequently Asked Questions for Hospitals and Critical Access Hospitals regarding EMTALA*, CMS, at 7 (Apr. 30, 2020), <https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf> (“If the [medical screening examination] is appropriate and does not reveal an [emergency medical condition], the hospital has no further obligation.”).

34. *Sampson v. Ukiah Valley Med. Ctr.*, No. 15-cv-00160, 2017 U.S. Dist. LEXIS 102452, at *23 (N.D. Cal. June 30, 2017) (“EMTALA does not penalize a hospital for providing a screening that falls beneath the relevant standard of care. Instead, the statute’s focus is to prevent ‘disparate’ screenings.”); *Merry v. Edwards*, No. 41350, 2019 N.Y. Misc. LEXIS 7190, at *6–7 (N.Y.S.3d Jan. 31, 2019) (“EMTALA requires only that a patient is screened in a manner consistent with the screening that any other patient with similar symptoms would have received.”) (citation omitted).

35. *Reynolds v. Me. Gen. Health*, 218 F.3d 78, 83 (1st Cir. 2000) (noting that numerous courts have stated that EMTALA is not a federal malpractice statute); *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143–45 (4th Cir. 1996) (explaining that EMTALA is not a state malpractice statute); see also Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA’s Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 647–48 (2007).

36. In the words of one court, “[A]ppropriate’ is one of the most wonderful weasel words in the dictionary[.]” *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

37. *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (“[EMTALA] is intended not to ensure each emergency room patient a correct diagnosis, rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances.”).

38. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 31403, 31477 (May 9, 2002) (adopting a “definition of ‘dedicated emergency department’ that does not reference special equipment or staffing but does recognize departments or facilities that are held out to the public as places that provide care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”).

39. *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1168 (9th Cir. 2002) (holding that while hospitals cannot avoid EMTALA by admitting and then immediately discharging a patient, “EMTALA’s

Because one of the reasons that prior efforts to combat patient dumping had failed was the lack of a substantial enforcement mechanism and sufficiently serious penalties, Congress sought to equip EMTALA with “teeth.”⁴⁰ Enforcement of EMTALA is the responsibility of the federal Department of Health and Human Services (HHS), specifically its Center for Medicare and Medicaid Services (CMS) and, to a lesser extent, the Office of the Inspector General (OIG).⁴¹ EMTALA investigations are complaint triggered, and those complaints can originate from an individual or a hospital, including from a hospital’s self-report.⁴² Hospitals are not only potentially liable for not properly screening and treating a patient, they may also face liability from another facility for improperly transferring a patient, and these compliance questions have generated both clarifying memos from CMS and

stabilization requirement ends when an individual is admitted for inpatient care”); *see also* Charlotte Fillenwarth, *Beyond the Emergency Room Doors: Rejecting Patient Admittance as Satisfaction of Hospital Obligations Under EMTALA*, 11 IND. HEALTH L. REV. 791, 813, 817 (2014).

40. I note that access to medical care in the U.S. has also been impacted by the 2010 (and 2014) passage of the Patient Protection and Affordable Care Act (ACA). Although this article focuses on EMTALA, the ACA not only impacted the ability of patients to access insurance and more routine care, it also impacted the utilization of emergency room care, especially among certain sub-populations. *See generally* Ryan M. McKenna et al., *Examining EMTALA in the Era of the Patient Protection and Affordable Care Act*, 5 AIMS PUB. HEALTH 366, 368 (2018).

41. U.S. GOV’T ACCOUNTABILITY OFF., GAO-01-747, *Emergency Care, EMTALA Implementation and Enforcement Issues*, 1 (2001) (“The regional offices of the Department of Health and Human Services’ (HHS) Center for Medicare and Medicaid Services (CMS) are responsible for investigating complaints of alleged EMTALA violations and forwarding confirmed violations to HHS’ Office of Inspector General (OIG) for possible imposition of civil monetary fines.”) (internal footnote omitted). CMS is the successor to the Health Care Financing Administration (“HCFA”). *Program Memorandum Intermediaries/Carriers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 24, 2001), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB01133.pdf> (“A June 14, 2001 press release announced that the name of the Health Care Financing Administration (HCFA) was changed to the Centers for Medicare & Medicaid Services (CMS).”). Note that while the federal Office for Civil Rights (OCR) can also play an enforcement role in EMTALA cases, that authority is derived from specific federal civil rights laws not a focus of this article. *State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf (last visited Oct. 13, 2023) (noting that if there is a suspicion that emergency services were denied based on race, color, national origin, age, disability, or sex that case should be forwarded to OCR for investigation).

42. *Contact Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation> (last visited Mar. 27, 2023).

litigation.⁴³ CMS has ten nationwide offices that authorize EMTALA investigations and determine if violations have occurred.⁴⁴ Hospitals found to be in violation have ninety days to submit a plan to correct the deficiencies found, and most complaints are resolved in this fashion if CMS accepts the proffered plan.⁴⁵ However, both hospitals and individual physicians violating EMTALA are also subject to civil monetary penalties enforced by the OIG, and patients harmed by violations of the law have a personal right of action.⁴⁶ In addition, hospitals out of EMTALA compliance may be excluded from participating in Medicare.⁴⁷

43. Appendix D EMTALA, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., <https://one.nhtsa.gov/people/injury/ems/interfacility/pages/AppD.htm#:~:text=Under%20EMTALA%2C%20patient%20care%20during,be%20> (last visited Oct. 13, 2023) (explaining the three basic obligations hospitals have under EMTALA). Note that “reverse dumping” is also an EMTALA violation. This occurs when a hospital refuses an appropriate EMTALA transfer regarding a patient sent to receive specialized treatment. Reverse dumping has also been the subject of litigation. *See, e.g.*, *St. Anthony Hosp. v. U.S. Dept. of Health & Hum. Servs.*, 309 F.3d 680 (10th Cir. 2002); *see also* Ercan E. Iscan, *EMTALA's Oft-Overlooked “Reverse Dumping” Provision and the Implications for Transferee Hospital Liability Following St. Anthony Hospital*, 82 WASH. UNIV. L. Q. 1201 (2004).

44. Memorandum from CMS Directors, Quality, Safety & Oversight Group (QSOG) on State Operations Manual (SOM) Emergency Medical Treatment and Labor Act (EMTALA) and Death Associated With Restraint or Seclusion Complaint Investigation Timeline Revisions to State Survey Agency Directors, (June 4, 2019), QSO-19-14-Hospitals [hereinafter June CMS Memo]; *see also* *CMS Regional Offices*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 15, 2022, 1:38 PM), <https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices>.

45. Sophie Terp et al., *Enforcement of the Emergency Medical Treatment and Labor Act, 2005 to 2014*, 69 ANNALS EMERGENCY MED. 155 (2017).

46. *See generally* Fell, *supra* note 29. Individual doctors, although penalized less often than hospitals, face fines of up to \$50,000 per incident, and such penalties are not covered by malpractice insurance. Sophie Terp et al., *Individual Physician Penalties Resulting from Violation of Emergency Medical Treatment and Labor Act: A Review of Office of the Inspector General Patient Dumping Settlements, 2002–2015*, 24 ACAD. EMERGENCY MED. 442, 444 (2017). Hospital fines, while previously set at \$50,000 per violation, were adjusted in November 2015, 42 C.F.R. § 1003.510, and are now subject to yearly inflation increases, 42 C.F.R. § 102 (2016).

47. Amrita Shenoy et al., *The Impact of EMTALA on Medical Malpractice Framework Models: A Review*, 16 PATIENT SAFETY IN SURGERY 21, at 2 (2022) (noting that penalties for violations of EMTALA can include exclusion from Medicare reimbursement); Charleen Hsuan et al., *Complying with the Emergency Medical Treatment and Labor Act (EMTALA): Challenges and Solutions*, J. HEALTHCARE RISK MGMT. (Nov. 8, 2017), at 3 (noting that penalties for EMTALA violations can include exclusion from Medicare). Exclusion from Medicare by having provider agreements terminated is a powerful tool in the fight against patient dumping. In a multi-year retrospective study, of the twelve hospitals that had their federal contracts canceled, the majority suffered at least temporary facility closure and or downgrading of emergency services. Terp et al., *supra* note 45, at 6.

III. EMTALA UP UNTIL THE *DOBBS* DECISION

EMTALA is widely believed to be the most effective tool against patient dumping employed thus far. For example, out of an estimated ninety-seven million emergency room visits to EMTALA-covered emergency rooms in a single evaluated year, CMS conducted less than 500 complaint-initiated investigations, of which approximately half resulted in a finding that a violation had occurred.⁴⁸ Various studies have found that the number of EMTALA complaints and violations have waxed and waned over the years, dependent on a variety of economic and insurance contexts and on the subpopulations examined. For example, one study focusing on EMTALA and patients presenting with a psychiatric disability noted an overall increase in EMTALA violations through the 1990s.⁴⁹ Other reviews have found that while EMTALA has been overall effective, investigations and violations continue to happen.⁵⁰ And a retrospective study looking at EMTALA investigations between 2005 and 2014 found that the number of hospitals investigated and cited decreased between the years studied.⁵¹ It should also be noted that while EMTALA entitles presenting patients to an emergency room safety net for critical care, hospitals can still bill patients for the care received after they leave.⁵²

For purposes of this article, some of the more important questions around pre-2022 EMTALA involve the frequency of pregnancy complications that arise under the law, the populations most involved in EMTALA complaints and investigations, and the demographics of the facilities subjected to EMTALA investigations. Although data in all of these areas is scarcer than hoped, there are studies evaluating the types of care involved in EMTALA investigations and the demographics of the patients and hospitals implicated. Labor and other obstetrical

48. U.S. Gen. Acct. Off., *Emergency Care EMTALA Implementation and Enforcement Issues 17–18* (2001), <https://www.gao.gov/assets/gao-01-747.pdf>.

49. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 8.

50. Brenda Goodman & Andy Miller, *Lives Lost Amid ER Violations, Investigation Finds*, GA. HEALTH NEWS (Nov. 29, 2018), <https://www.georgiahealthnews.com/2018/11/investigation-finds-lives-lost-er-violations/> (analyzing 4,300 EMTALA violations at 1,682 hospitals over a decade); Kija Blalock & Sidney M. Wolfe, *Questionable Hospitals, 527 Hospitals That Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at “Patient Dumping”*, PUB. CITIZEN (July 2001), <https://www.citizen.org/wp-content/uploads/qhcompletereport.pdf>.

51. Sophie Terp et al., *supra* at note 45, at 2. The study found that that an average of 9% of hospitals were investigated yearly during the study. *Id.* Of these just over 4% were annually cited. *Id.* “The proportion of hospitals subject to EMTALA investigations decreased from 10.8% to 7.2%, and citations from 5.3% to 3.2%, between 2005 and 2014.” *Id.*

52. Additionally, as new situations, such as the COVID-19 pandemic, present themselves, CMS has issued ongoing amendments and published guiding principles. *See Frequently Asked Questions for Hospitals and Critical Access Hospitals Regarding EMTALA*, CMS (Apr. 30, 2020), <https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf>.

complications are among the most common reasons for EMTALA complaints and investigations.⁵³ One review found that one in six EMTALA related OIG settlements involved obstetrical care, most often because of a failure to properly screen or stabilize the patient.⁵⁴ A thirteen-year study of EMTALA investigations that resulted in monetary penalty settlements found that settlements most commonly occurred in hospitals located in urban areas and in southern states.⁵⁵ CMS sent out a memo pre-*Dobbs* to clarify hospital obligations under EMTALA for patients experiencing pregnancy loss or complications.⁵⁶ In this directive, CMS reminded hospitals that stabilizing treatment for pregnant patients with emergency medical conditions could include abortion.⁵⁷

IV. THE *DOBBS* DECISION

The direct clash between EMTALA and abortion health care originated in 2018, when the state of Mississippi passed House Bill 1510, “An Act to . . . Prohibit Abortions After 15 Weeks Gestation.”⁵⁸ This bill was a direct challenge to federal law,⁵⁹ and when he signed the bill in March 2018, then Mississippi Governor Phil Bryant acknowledged that the new law was ripe for litigation.⁶⁰ The law was immediately challenged, resulting in a temporary restraining order that stopped the law from taking effect.⁶¹ Eight months later, the plaintiffs won summary judgment

53. Terp et al., *supra* note 45, at 157 (finding that between 2005 and 2014 active labor and other obstetric emergencies comprised 14% of the total number of EMTALA citations. The two larger categories were medical and psychiatric emergencies).

54. Sophie Terp et al., Penalties for Emergency Medical Treatment and Labor Act Violations Involving Obstetrical Emergencies, 21 W. J. EMERGENCY MED., 235, 236 (2020).

55. McKenna et al., *supra* note 40, at 367. Note that OIG publishes parenthetical descriptions of every EMTALA settlement they are involved in on their website. The most recent available data is for 2020 and can be found at: *Civil Monetary Penalties and Affirmative Exclusions*, U.S. DEPT. OF HEALTH & HUM. SERVS.: OFF. OF INSPECTOR GEN. (2020), <https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp>.

56. Memorandum from CMS Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG) on Reinforcement of EMTALA Obligations to State Survey Agency Directors (Sept. 17, 2021) (revised Oct. 3, 2022), QSO-21-22-Hospitals [hereinafter Sept. CMS Memo].

57. *Id.* at 4.

58. H.B. 1510, Reg. Sess. (Miss. 2018).

59. *Id.* House Bill 1510 was a challenge to the law under both *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

60. See *Mississippi Governor Signs Bill Imposing Nation’s Toughest Abortion Ban*, CBS NEWS (Mar. 19, 2018), <https://www.cbsnews.com/news/mississippi-governor-phil-bryant-signs-bill-imposing-nations-toughest-15-week-abortion-ban/> (“We’ll probably be sued in about half an hour. That’ll be fine with me. It’ll be worth fighting over.”).

61. *Jackson Women’s Health Org. v. Currier*, No. 3:18-CV-171-CWR-FKB, 2018 WL 1567867, at *1 (S.D. Miss. Mar. 20, 2018). Note that while the case has come to be known as *Dobbs v. Jackson*, it was

on the single question before the court at that time: whether the 15-week mark mandated by the proposed law was before or after viability.⁶² The case then made its way to the United States Court of Appeals for the Fifth Circuit, which heard arguments before a three judge panel sitting in New Orleans.⁶³ That panel issued their opinion in December 2019, unanimously affirming the district court's opinion.⁶⁴ In 2020, Mississippi sought a writ of certiorari from the U.S. Supreme Court, which was granted on May 17, 2021 on the single question of whether all pre-viability prohibitions on elective abortions were unconstitutional.⁶⁵ Over eighty amicus curiae briefs were filed in the case.⁶⁶ Oral argument was held on December 1, 2021.⁶⁷ Six months later, on June 24, 2022, the U.S. Supreme Court issued its

originally filed as *Jackson Women's Health Center v. Currier*, 320 F. Supp. 3d 828 (2018). When the case was initiated in March 2018, Mary Currier was the State Health Officer of the Mississippi Department of Health. She retired at the end of that calendar year, and Dr. Thomas Dobbs, an infectious disease specialist, took over that position. *Id.*

62. *Jackson Women's Health Org. v. Currier*, 349 F. Supp. 3d 536, 539 (S.D. Miss. 2018). Note that in the months between issuance of the injunction and of the summary judgment order the temporary restraining order was extended multiple times and the case was bifurcated. *Id.* at 538. In the summary judgment ruling the judge wrote that he was aware that the true motive behind passage of such a blatantly improper law was to get to the Supreme Court to overturn *Roe v. Wade*, stating, "With the recent changes in the membership of the Supreme Court, it may be that the State believes divine providence covered the Capitol when it passed this legislation. Time will tell." *Id.* at 544–45.

63. *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019), *rev'd and remanded*, 142 S. Ct. 2228 (2022).

64. *Id.* at 277.

65. *Dobbs v. Jackson Women's Health Org.*, 141 S. Ct. 2619 (2021).

66. Note that this author's non-profit organization, Legal Voice, submitted an *amicus curiae* brief on behalf of themselves and thirteen other organizations, referred to in the *Dobbs* dissent. This brief explained that the court had to focus on the effect the fifteen-week ban would have on all communities, including survivors of intimate partner violence, and particularly black, indigenous, and other people of color survivors of intimate partner violence, communities that live at the intersection of multiple forms of oppression and are more likely to need abortions. The brief explained that Mississippi's law would increase the control of abusers and further burden survivors of intimate partner violence. See Brief of Amici Curiae Legal Voice, On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit, *Dobbs v. Jackson Women's Health Org.*, 141 S. Ct. 2619 (2021) (No. 19-1392). See generally Case Documents for 19-1392, SUPREME CT. OF THE U.S., <https://www.supremecourt.gov/docket/docketfiles/html/public/19-1392.html> (last updated July 26, 2022).

67. Oral Argument, *Dobbs v. Jackson Women's Health Org.*, 141 S. Ct. 2619 (2022) (No. 19-1392), <https://www.oyez.org/cases/2021/19-1392>.

opinion in *Dobbs v. Jackson Women’s Health Organization*, overturning decades of precedent and returning the regulation of abortion care to the states.⁶⁸

When the *Dobbs* decision was issued, a number of states already had laws on the books banning or severely limiting the availability of abortion care.⁶⁹ Some of these laws were from the pre-*Roe v. Wade* era and had never been officially repealed when the *Roe* decision made them moot.⁷⁰ A number of states had also passed “trigger” laws during the period between Mississippi’s passage of House Bill 1510 in 2018 and the *Dobbs* decision, as state legislators bet on the chance that the Supreme Court would overturn the *Roe* and *Casey* decisions.⁷¹ And a third category were anti-abortion laws that had been passed in defiance of *Roe* and *Casey*.⁷² Following *Dobbs*, there was a fourth category of anti-abortion laws—those that were passed once the Supreme Court officially gave the authority to regulate abortion to the states.⁷³

Many commentators have analyzed the holding, reasoning, and future impact of the *Dobbs* decision, both domestically and internationally.⁷⁴ It is a landmark decision and its impacts will continue to be felt in the years to come;⁷⁵ however,

68. *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022) (overturning both *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992)).

69. Elyssa Spitzer & Maggie Jo Buchanan, *2022 State Abortion Bans Are a Patchwork of Increasingly Extreme Laws*, *CTR. FOR AM. PROGRESS* (May 20, 2022).

70. Cong. Rsch. Serv., R47595, *State Laws Restricting or Prohibiting Abortion*, 1 (June 16, 2023).

71. *Id.* So called trigger laws are laws that only go into effect after an intervening event—a trigger. Under anti-abortion trigger laws, the trigger is either passage of a U.S. constitutional amendment returning the authority to regulate abortion to the states, or a U.S. Supreme Court decision having the same effect. Once the trigger is pulled the anti-abortion law becomes effective a certain number of days after the triggering event. *Id.* at 1–2.

72. *Id.* at 1.

73. Kelly Baden & Jennifer Driver, *The State Abortion Policy Landscape One Year Post-Roe*, *GUTTMACHER INST.* (June 2023), <https://www.guttmacher.org/2023/06/state-abortion-policy-landscape-one-year-post-roe>.

74. See, e.g., David S. Cohen et al., *The New Abortion Battleground*, 123 *COLUM. L. REV.* 1 (2023); Risa Kaufman, et al., *Global Impacts of Dobbs v. Jackson Women’s Health Organization and Abortion Regression in the United States*, *SEXUAL & REPROD. HEALTH MATTERS*, 30(1) (2022); *Explaining SCOTUS’s Abortion Decision in Dobbs v. Jackson Women’s Health Organization*, *LEAGUE OF WOMEN VOTERS* (July 22, 2022), <https://www.lwv.org/blog/explaining-scotuss-abortion-decision-dobbs-v-jackson-womens-health-organization>; *The Dobbs v. Jackson Decision, Annotated*, *N.Y. TIMES* (June 24, 2022), <https://www.nytimes.com/interactive/2022/06/24/us/politics/supreme-court-dobbs-jackson-analysis-roe-wade.html>.

75. I must note that another potential consequence of the *Dobbs* decision lies in an area related to this article’s focus: the potential consequences for Food and Drug Administration (FDA) approval of

for purposes of this article, I focus on the Court's central holding—overturning prior precedent and giving the authority to regulate or prohibit abortion to the states—and the resulting conflict between EMTALA and no-access states.⁷⁶

V. THE STATE OF TWO STATES WHEN *DOBBS* IS PUBLISHED

The decision in *Roe v. Wade* was published in 1973 and EMTALA became law in 1986.⁷⁷ As explained above, EMTALA represented a national effort to combat issues of substandard patient care, epitomized by the practice of patient dumping, and has become an accepted part of the legal and medical landscape.⁷⁸ But to state the obvious, EMTALA has never before been interpreted in a context where there is not a federally accepted right to reproductive health care that includes abortion.

It was immediately clear to officials in the government, particularly in HHS, that states moving to ban or severely restrict access to abortion health care after *Dobbs* could generate a conflict with EMTALA's mandate.⁷⁹ As explained above, EMTALA proscribes stabilizing care for all patients presenting at a covered emergency department that are found to have an emergency medical condition.⁸⁰ This stabilizing care, pre-*Dobbs*, was defined as including the provision of abortion care in medically appropriate circumstances.⁸¹ Because EMTALA broadly defines an emergency medical condition, HHS was concerned that states would either (a) try to exclude abortion care completely, even when medically appropriate or (b) only

abortion drugs. Although the FDA is, by law, the only agency that can approve and regulate drugs in this country, state law may not be expressly preempted. There is already a post-*Dobbs* lawsuit challenging the FDA's decades old approval of mifepristone, the first drug typically used in a two-drug abortion medication regimen. A second case was more recently filed, seeking to remove the FDA's restrictions around mifepristone. As of this writing, there is not yet a decision in either case's motion for a preliminary injunction. See *Alliance for Hippocratic Medicine et al., v. U.S.F.D.A.*, CA No. 2:22-CV-00223 (Nov. 18, 2022) (complaint available at <https://clearinghouse.net/doc/135215/>); *State of Washington et al., v. U.S.F.D.A. et al.*, CA No. 1:23-CV-03026 (2022) (complaint available at https://agportalreys3bucket.s3.amazonaws.com/uploadedfiles/Another/News/Press_Releases/Mifepri stone%20Complaint.pdf).

76. I have previously written on the importance of state constitutions in the adjudication of human rights principles, as state level constitutions are flexible documents amenable to modification and offer a forum for greater individual protections that go beyond federal constitutional mandates. Wendy Heipt, *Implementing the RTF in America*, 22 CONN. PUBL. INT. L. J. 1 (2023); Wendy Heipt, *The Right to Food Comes to America*, 17 J. OF FOOD L. & POL'Y 2 (2022).

77. *Roe v. Wade*, 410 U.S. 113 (1973); 42 U.S.C. § 1395dd.

78. See *supra*, The History Behind EMTALA.

79. See *infra*, EMTALA, Federal Law and State Law: Rethinking Post-*Dobbs*.

80. See *supra*, The Requirements of EMTALA.

81. See Sept. CMS Memo, *supra* note 56, at 1.

allow abortion care in a much narrower set of medical circumstances than EMTALA allows—for instance only when the pregnant person is near death.⁸²

In Texas the anti-abortion laws stem from three of the four above-enumerated categories.⁸³ First, the state maintained that their pre-*Roe* anti-abortion laws became enforceable again after the *Dobbs* decision.⁸⁴ Second, in 2021, the Texas governor signed a trigger law entitled the Texas Human Life Protection Act.⁸⁵ This Act criminalizes providers for engaging in any abortion procedure.⁸⁶ While the Act has very narrow exemptions for the life or health of the pregnant person, discussed *infra*, it does not have some of the exceptions found in

82. The concern regarding laws in states with no or reduced access to abortion care, like Idaho and Texas, was such: if a pregnant person showed up at a private hospital emergency department with preeclampsia in January 2022, a standard of care approach could be terminating that pregnancy to avoid the onset of sepsis. If that same pregnant person presented at that same emergency department in Idaho or Texas in December 2022, the attending provider was in a different position. Although the medical standard of care had not changed, terminating that pregnancy would now subject that provider to civil sanctions and criminal liability under state law. But not terminating the pregnancy might impact the health and well-being of the pregnant patient and put the provider and the hospital in violation of EMTALA. And regardless of the choice that provider made, they were now having to add an extra step into patient care that would delay the process. Andrea MacDonald, MD et al., *The Challenge of Emergency Abortion Care Following the Dobbs Ruling*, JAMA 328(17) (Nov. 1, 2022). In other words, although the anti-abortion statutes in the two states highlighted here, Idaho and Texas, vary in some respects, their similarity is their perceived conflict with EMTALA. *Id.*

83. See *supra*, The *Dobbs* Decision (enumerating the four categories of abortion laws in the aftermath of *Dobbs*: (1) laws from the pre-*Roe* era that had never been repealed, (2) laws passed between *Roe* and *Dobbs* in defiance of federal law, (3) trigger laws passed and awaiting *Dobbs*, (4) laws passed after the *Dobbs* decision was issued).

84. While, in general, prior laws on a subject subsequently legislated are assumed to be superseded, in this case the validity of Texas' pre-*Roe* anti-abortion laws are unclear. After one court blocked prosecutions under the pre-*Roe* laws, another court stayed that ruling. *Whole Woman's Health v. Paxton*, No. 2022-38397, 2022 WL 2314499, at *1 (D. Tex. June 27, 2022); *In re Paxton*, No. 22-0257, 2022 WL 2425619, at *1 (Tex. July 1, 2022).

85. The relevant section of the legislation presented to the Governor read as follows: this Act takes effect, to the extent permitted, on the 30th day after: (A) the issuance of a United States Supreme Court judgement overruling, wholly or partly, *Roe v. Wade*, 410 U.S. 113 (1973), as modified by *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), thereby allowing the states of the United States to prohibit abortion; (B) the issuance of any other United States Supreme Court judgment in a decision that recognizes, wholly or partly, the authority of the states to prohibit abortion; or (C) adoption of an amendment to the United States Constitution that, wholly or partly, restores to the states the authority to prohibit abortion. H.B. 1280, 87th Leg. (Tex. 2021).

86. The potential criminal penalty for violating this law is anywhere from two years to life in prison and a civil penalty of at least \$100,000. TEX. HEALTH & SAFETY CODE ANN. §§ 170A.001– 170A.007 (West 2022).

other states, such as for victims of rape or incest.⁸⁷ Third, Senate Bill 8 was enacted before the fall of *Roe*. This law outlawed abortion after approximately six weeks, and also did not provide any exceptions for rape or incest.⁸⁸ Thus, at the moment that the *Dobbs* decision was issued, Texas already had numerous laws restricting abortion.⁸⁹

Likewise, the state of Idaho was also restricting abortion through a pair of laws that together banned abortion in almost every circumstance. First, Idaho has a law modeled after Texas' Senate Bill 8, which outlaws abortions at approximately six weeks.⁹⁰ Idaho also passed its own trigger law, known as the Total Abortion Ban, which took effect on August 25, 2022.⁹¹ Under the Total Abortion Ban, any provider performing or attempting to perform an abortion commits a felony punishable by two to five years imprisonment. While Idaho's Total Abortion Ban contained no exceptions, it did contain two affirmative defenses—one of which was to prevent the death of the pregnant person. As written, this affirmative defense was only available if the abortion was performed in a manner that “provided the best opportunity for the unborn child to survive, unless, in [the physician's] good faith medical judgment, termination of the pregnancy in that manner would have posed

87. *Id.* at § 170A-002.

88. S.B. 8, 87th Leg. (Tex. 2021).

89. Note that even before the *Dobbs* decision, abortion care in Texas was difficult to obtain. Before *Roe v. Wade* legalized abortion at the federal level, Texas law contained a number of statutes that criminalized abortion, statutes that were never repealed after the publication of the *Roe* decision. TEX. REV. CIV. STAT. ANN. arts. 4512.1–.4, .6. (West 2010) (former TEX. PENAL CODE arts. 1191–1194, 1196 (1925)). Although the Fifth Circuit held that these were implicitly repealed in *McCorvey v. Hill*, 385 F.3d 846, 849 (5th Cir. 2004), and the ban was temporarily enjoined in *Whole Woman's Health*, 2022 WL 2314499, at *1, the Texas supreme court allowed for civil enforcement in the appeal of that case on July 1, 2022. *In re Paxton*, 2022 WL 2425619, at *1. Further, a 2017 study comparing number of miles patients across the U.S. had to travel to access abortion care found that Texas had the most cities (ten out of twenty-seven) where patients had to travel over one hundred miles to get an abortion. Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20 J. MED. INTERNET RSCH., no. 5, 2018, at 1. Even those patients able to travel to an abortion provider in Texas before the *Dobbs* decision were subject to some of the most severe restrictions in the nation: a parental consent requirement, a barrage of TRAP laws (TRAP stands for “targeted regulation of abortion providers” and refers to medically unnecessary laws that are used to single out the provision of abortion services), limited funding, a mandatory waiting period, and a limited number of available abortion procedures. Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States*, THE GUTTMACHER INST. (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>; see generally *Abortion in Texas*, CTR. FOR REPROD. RTS. (2022), <https://reproductiverights.org/case/texas-abortion-ban-us-supreme-court/abortion-in-texas/>.

90. IDAHO CODE §§ 18-8801 to -8808 (2022).

91. IDAHO CODE § 18-622 (2022).

a greater risk of the death of the pregnant woman.”⁹² Thus, at the moment that the *Dobbs* decision was issued, both Idaho and Texas had laws outlawing abortion in emergency departments. Idaho had no exceptions to their ban, and Texas had only a very narrow exception.

VI. EMTALA, FEDERAL LAW AND STATE LAW: RETHINKING POST-DOBBS

In the weeks after issuance of *Dobbs*, legal scholars, politicians, and the citizenry at large remained unclear as to how the decision would affect numerous state and federal statutes and several areas of law, including EMTALA. One of the first federal responses to the potential conflict between EMTALA and state law came in the form of an Executive Order issued by President Joe Biden.⁹³ Entitled *Executive Order on Protecting Access to Reproductive Health Care Services*, this order reiterated the administration’s position that personal health care decisions should be made without government interference and, *inter alia*, instructed the Secretary of HHS to report on potential avenues of protecting reproductive health care options, including abortion access.⁹⁴

In response to President Biden’s Executive Order and in recognition of the fact that hospital administrators and staff might be confused regarding their continuing obligations under EMTALA in light of restrictive state laws, HHS Secretary Xavier Becerra issued a letter⁹⁵ and CMS sent a memorandum,⁹⁶ to clarify hospital and

92. IDAHO CODE § 18-622(3)(a) (2022). Note that while exceptions mean that the law at issue is inapplicable under the language of the exception, an affirmative defense means that the individual is still charged with a crime, still has to go to court to defend themselves, and must prove that they are entitled to the affirmative defense at issue through a preponderance of the evidence. The other affirmative defense in the Idaho Total Abortion Ban was for rape or incest, but only if those crimes had been reported to law enforcement and a copy of the police report was presented to the physician. IDAHO CODE § 18-622(3)(b).

93. Note that even prior to the issuance of *Dobbs*, the U.S. Department of Justice had organized a working group in anticipation of the decision. After the *Dobbs* decision came out, this working group was formalized as the Reproductive Rights Task Force, chaired by Associate Attorney General Vanita Gupta. Press Release No. 22-739, U.S. Dep’t of Just., Just. Dep’t Announces Reproductive Rights Task Force (July 12, 2022), <https://www.justice.gov/opa/pr/justice-department-announces-reproductive-rights-task-force>.

94. Exec. Order No. 14076, 87 Fed. Reg. 42053 (Jul. 8, 2022); *see also* Exec. Order No. 14079, 87 Fed. Reg. 49505 (Aug. 3, 2022).

95. Letter from Xavier Becerra, Secretary of Health and Human Services, to Health Care Providers (July 11, 2022), <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

96. Memorandum from CMS Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG) to State Survey Agency Directors (July 11, 2022, revised Aug. 25, 2022) [hereinafter *CMS July Memo*], <https://www.cms.gov/files/document/qso-22-22-hospitals.pdf>; *see also* *CMS Sept. Memo*, *supra* note 56.

physician obligations. The memo noted that its' purpose was to "restate existing guidance" and to "remind hospitals of their existing obligation to comply with EMTALA and does not contain new policy."⁹⁷ It explained the appropriate course of action under EMTALA:

The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary, ***irrespective of any state laws or mandates that apply to specific procedures.***

A physician's professional and legal duty to provide stabilizing medical treatment to a patient who presents under EMTALA to the emergency department and is found to have an emergency medical condition ***preempts any directly conflicting state law or mandate*** that might otherwise prohibit or prevent such treatment.

If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician ***must*** provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — ***that state law is preempted.***⁹⁸

The memorandum then reiterated EMTALA's obligations to screen and then stabilize/transfer presenting patients and noted that "a hospital is restricted by EMTALA to transfer patients only after a physician certifies that the medical benefits of the transfer outweigh the risks."⁹⁹ The memo stated that:

A hospital cannot cite State law or practice as the basis for transfer. Fear of violating state law through the transfer of the patient cannot prevent the physician from effectuating the transfer nor can the physician be shielded from liability for erroneously complying with state laws that prohibit services such as abortion or transfer of a patient for an abortion when the original hospital does not have the capacity to provide such services. When a direct conflict occurs between EMTALA and a state law, EMTALA must be followed.

97. *CMS July Memo*, *supra* note 96.

98. *Id.*

99. *Id.*

[T]he determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., methotrexate therapy, dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.).

Any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital would be preempted by the federal EMTALA statute due to the direct conflict with the “stabilized” provision of the statute. Moreover, EMTALA contains a whistleblower provision that prevents retaliation by the hospital against any hospital employee or physician who refuses to transfer a patient with an emergency medical condition that has not been stabilized by the initial hospital, such as a patient with an emergent ectopic pregnancy, or a patient with an incomplete medical abortion.¹⁰⁰

After issuing the original letter and memorandum in July, Secretary Becerra followed up with a letter to state governors in August, 2022.¹⁰¹ In this communication Secretary Becerra noted nationwide reports of pregnant people being denied care or having their care delayed, and reiterated that HHS was working “to ensure that individuals have access to the medical care to which they are entitled, regardless of directly conflicting state law” and that “HHS will not hesitate to refer the matter to the Department of Justice to take appropriate legal action.”¹⁰² The federal government also launched a website to provide real time guidance to the state of the laws around the United States in the aftermath of the *Dobbs* case.¹⁰³ Also in August 2022, HHS published a report outlining their efforts to preserve abortion care, including under EMTALA, and emphasized that the state of

100. *Id.*

101. Letter from Xavier Becerra, HHS Secretary, and Chiquita Brooks-LaSure, HHS Administrator, to Governors (Aug. 26, 2022), <https://www.hhs.gov/sites/default/files/hhs-letter-to-governors-reproductive-health-care.pdf>.

102. *Id.*

103. See REPRODUCTIVERIGHTS.GOV, <https://reproductiverights.gov> (last visited July 3, 2023).

abortion access (and the interplay between federal and state law), was quickly evolving.¹⁰⁴ In other words, it was almost immediately clear that state anti-abortion laws in effect after the *Dobbs* decision were on a collision course with EMTALA.

VII. IDAHO AND TEXAS EMTALA LAWSUITS

Three days after the HHS July 2022 memo was issued, the Texas Attorney General brought a lawsuit against the Department of Health and Human Services in the United States District Court for the Northern District of Texas.¹⁰⁵ In its opening paragraph the complaint alleged that the HHS July memo attempted to “use federal law to transform every emergency room in the country into a walk-in abortion clinic” and alleged several causes of action.¹⁰⁶

Overall, Texas’ argument can be summarized as follows:¹⁰⁷ Because the HHS July memo could be read as mandating abortion care when a pregnant person presented with a serious medical concern at an EMTALA covered emergency department, and because the Texas state standard of care did not include abortion, and because EMTALA itself does not “mandate, direct, approve, or even suggest the provision of any specific treatment,”¹⁰⁸ the HHS abortion “mandate” was an attempt to dictate a standard of care¹⁰⁹ that put Texas doctors in the untenable position of “having to choose between violating state law under threat of criminal

104. HHS, HEALTH CARE UNDER ATTACK (2022), <https://www.hhs.gov/sites/default/files/hhs-report-reproductive-health.pdf>.

105. Complaint, *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 WL 3639525 (N.D. Tex. Aug. 23, 2022) [hereinafter *Texas Complaint*]. Two plaintiffs representing provider organizations opposed to abortions joined the Texas Attorney General. *Id.*

106. *Id.* The worry that the requirements of EMTALA conflict with other laws limiting reproductive health care have existed before the *Dobbs* case. For example, there have previously been concerns raised that EMTALA could conflict with federal health care provider conscience protection statutes. In response to these concerns, HHS published a rule that reiterated the obligation of all covered entities to continue to comply with their other obligations, including EMTALA, regardless of their other available protections. 45 C.F.R. § 88 (2011).

107. In addition to the arguments detailed above, the complaint also alleged two *ultra vires* causes of action: that the HHS July memo authors were attempting to institute a national right to abortion in an unconstitutional delegation of legislative power, *Texas Complaint*, *supra* note 105, at 17, and that the HHS July memo was an unconstitutional exercise of authority in violation of the Tenth Amendment, *id.* at 18.

108. *Id.* at 5.

109. Additionally, although EMTALA holds that it preempts state law requirements “to the extent that the requirement directly conflicts with a requirement of [EMTALA]” 42 U.S.C. § 1395dd(f), the *Texas Complaint* alleged that the HHS memo’s directive that EMTALA preempts state laws with overly narrow exceptions that do not align with EMTALA’s definition of an emergency medical condition was a never-before-seen aspect of the EMTALA statute.

penalty or jeopardizing their ability to participate in Medicaid.”¹¹⁰ While the complaint did not challenge the overall acceptability of conditioning Medicare funds on complying with EMTALA, it did assert that, in essence, the HHS July memo changed the terms of that agreement by making receipt of Medicare funding dependent on performing a specific service (abortion care),¹¹¹ which was a new regulation not properly authored by the HHS Secretary¹¹² and an unconstitutional violation of the federal government’s spending power.¹¹³

Three weeks after filing its lawsuit, Texas moved for a preliminary injunction and a temporary restraining order, which the court ruled on in an August 23, 2022, decision.¹¹⁴ The district court held that the HHS July memorandum exceeded EMTALA in several respects.¹¹⁵ First, *inter alia*, despite HHS’ contrary characterization, the court held that the HHS July memo was not a restatement of prior law but a final and new agency action properly subject to review by the court.¹¹⁶ Second, the court found that Congress, through EMTALA, had not addressed what a provider should do if both the fetus and the pregnant person’s health were threatened and that those interests were equal.¹¹⁷ In that situation, HHS could not tell states how to apportion risks and could not read an abortion mandate into the statutory text to generate a conflict between federal law and state law.¹¹⁸ In other words, the HHS July memorandum could not remove the

110. Texas Complaint, *supra* note 105, at 10. As discussed above, because EMTALA litigation generally looks at whether the treatment provided is similar to that provided to other patients, Texas argued that the standard of care referenced should be that prevalent in the state of Texas, a state that does not include the provision of abortion care in any such standard. *Id.*

111. The complaint stated that the HHS July memo requiring “that a provider perform an abortion if ‘abortion is the stabilizing treatment necessary to resolve [an emergency medical condition]’” was the equivalent of a federal mandate to perform an abortion. *Id.* at 2.

112. Alternatively, the complaint stated even if the authors of the HHS July memo were permitted to promulgate a ‘new rule,’ they would still have had to provide procedurally required notice and comment requirements. *Id.* at 15. They also termed the memo an “arbitrary or capricious” action in violation of 5 U.S.C. § 706(2)(A). *Id.* at 16.

113. Such action would be in violation of 5 U.S.C. § 706(A)(c). *Id.* at 16–17.

114. Texas v. Becerra, No. 5:22-CV-185-H, 2022 WL 3639525 (N.D. Tex. Aug. 23, 2022).

115. *Id.* at *18.

116. *Id.* at *15.

117. *Id.* at *56; EMTALA’s definition of an emergency medical condition says that it includes a condition that could result in placing the health of the pregnant person or their unborn child in serious jeopardy. 42 U.S.C. § 1395dd(e)(1)(A)(i).

118. *Becerra*, 2022 WL 3639525, at *15. The *Becerra* court employed what is known as the *Chevron* deference test. *Id.* at * 19 (citing *Chevron U.S.A., Inc. v. Nat. Res.’s Def. Council, Inc.*, 467 U.S. 837 (1984)). Under this analysis courts must examine whether the agency at issue had Congressional authority to make force-of-law rules. If so, and if there is no clear Congressional intent on the matter,

health of the fetus concern from the EMTALA statute and mandate a result to a gap-filling state law that did not attempt to override Congressional intent, especially in an area traditionally the purview of the states.¹¹⁹ Third, the court noted that the primary purpose behind enactment of EMTALA was to curb the practice of patient dumping and Texas' anti-abortion law did not threaten that goal.¹²⁰ The court found that the plaintiffs had shown that they were likely to proceed on the merits of their claim that the HHS July memo exceeded the agency's authority and granted the preliminary injunction.¹²¹

In light of the court's ruling, HHS can no longer enforce its interpretation of EMTALA in Texas or against members of the American Association of Pro-Life Obstetricians and Gynecologists or against members of the Christian Medical and Dental Association and has revised its July letter and memorandum to reflect that. As of this writing, under the court's preliminary injunction, emergency departments in Texas can only provide abortion care to presenting patients when they are assessed to have conditions that are life-threatening or pose a serious risk of substantial impairment to a major bodily function.¹²² HHS filed a motion for

the court must then evaluate whether the agency's interpretation is a permissible one. (As the Texas court noted, the *Chevron* framework, "may have fallen out of favor," but that question is as yet undecided. *Becerra*, 2022 WL 3639525, at * 25 n. 11). Because the HHS Secretary has clear authority under § 1395hh(a)(1) and because EMTALA does not specifically mention abortion, the Texas court had to determine whether HHS's interpretation of the requirements under EMTALA as expressed in its July memorandum were a permissible construction of the statute. The court held that it was not. Note that HHS' interpretation of a statute is a separate interaction than one of its regulations, with the former being a *Chevron* deference test and the latter an *Auer* deference test. *See Auer v. Robbins*, 519 U.S. 452 (1997) (holding that agency interpretation of its regulations is controlling unless plainly erroneous).

119. *Becerra*, 2022 WL 3639525, at *20–21.

120. *Id.* at *22.

121. After the district court issued its opinion, HHS added the following language to their July memorandum:

Pursuant to the preliminary injunction in *Texas v. Becerra*, No. 5:22-CV-185-H (N.D. Tex.), HHS may not enforce the following interpretations contained in the July 11, 2022, CMS guidance (and the corresponding letter sent the same day by HHS Secretary Becerra): (1) HHS may not enforce the Guidance and Letter's interpretation that Texas abortion laws are preempted by EMTALA; and (2) HHS may not enforce the Guidance and Letter's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against the members of the American Association of Pro Life Obstetricians and Gynecologists (AAPLOG) and the Christian Medical and Dental Association (CMDA).

CMS July Memo, *supra* note 96.

122. Note that this state of the law has already spurned a lawsuit filed on behalf of Texans asserting that they were not provided abortion care in these circumstances. *Zurawski et al., v. Texas et al.*, Dist. Ct. Travis Cty., Tx, D-1-GN-23-000968 (March 6, 2023).

clarification on the scope of the preliminary injunction, which the court denied.¹²³ Most recently, the parties filed an updated joint status report and the federal government has appealed the court's order to the U.S. Court of Appeals for the Fifth Circuit.¹²⁴

The Idaho EMTALA lawsuit was initiated by the federal government in August 2022, in a suit seeking declaratory and injunctive relief.¹²⁵ In this suit, filed in the United States District Court for the District of Idaho, the government alleged that Idaho's Total Abortion Ban "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" in direct conflict with EMTALA's mandate and in violation of the Supremacy Clause.¹²⁶ The federal government also asserted that the lack of any exceptions in the Idaho law meant that providers at the thirty-nine impacted state hospitals¹²⁷ were subject to a "chilling effect" that itself impeded Congressional intent.¹²⁸ That same month, the district court issued its decision and granted the U.S. government's motion for a preliminary injunction.¹²⁹

In its decision, the Idaho district court found that Idaho's abortion ban and EMTALA were in conflict under both impossibility preemption and obstacle

123. *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 U.S. Dist. LEXIS 234344, at (N.D. Tex. Nov. 15, 2022).

124. See Joint Status Report, *Becerra*, No. 5:22-CV-00185-H, 2022 WL 3639525 (N.D. Tex. Dec. 9, 2022), <https://ia902501.us.archive.org/4/items/gov.uscourts.txnd.365015/gov.uscourts.txnd.365015.105.0.pdf>; Appeal from the United States District Court for the Northern District of Texas USDC No. 5:22-CV-00185, *Becerra*, No. 5:22-CV-00185-H, 2022 WL 3639525, filed, No. 22-11037 (5th Cir. Dec. 22, 2022), <https://storage.courtlistener.com/recap/gov.uscourts.txnd.365015/gov.uscourts.txnd.365015.107.0.pdf>.

125. Complaint at 3, *United States v. Idaho*, No. 1:22-CV-00329-BLW, 2022 WL 3137290 (D. Idaho Aug. 2, 2022) [hereinafter *Idaho Complaint*], <https://www.justice.gov/opa/press-release/file/1523481/download>.

126. *Id.* at 2–3.

127. *Id.* at 9. Note that while forty-three Idaho hospitals participate in Medicare, four of them do not have emergency departments subject to EMTALA. *Id.*

128. *Id.* at 10–11. As residents of one U.S. state may generally travel freely to another U.S. state, the implications of the interplay between EMTALA and state law resonate beyond Idaho, particularly with those states that share borders with Idaho. Because of this interconnection, twenty states and the District of Columbia intervened in the lawsuit as amici curiae. See Brief for the States of California et al. as Amici Curiae Supporting Plaintiff's Motion for a Preliminary Injunction, *United States v. Idaho*, No. 1:22-CV-00329-BLW (D. Idaho Aug. 16, 2022), WL 3644610, https://ag.ny.gov/sites/default/files/doc_51_us_v_idaho_amicus_brief.pdf.

129. *United States v. Idaho*, No. 1:22-CV-00329-BLW, WL 3692618, at *15 (D. Idaho Aug. 24, 2022).

preemption theories,¹³⁰ with EMTALA asking physicians to perform abortions when a patient's condition could reasonably be expected to result in serious jeopardy to their health and Idaho law banning all abortions.¹³¹ The court noted that one of EMTALA's purposes is to provide time-sensitive care in serious situations so that patients are stabilized before their condition progresses to a life-threatening emergency.¹³² The Idaho law frustrates this purpose, because doctors cannot perform a medically necessary procedure until the patient is in a life-and-death situation.¹³³

The court held that in such a case there was a clear constitutional answer to the dilemma: Article VI's Supremacy Clause.¹³⁴ At its core, the Supremacy Clause holds that when an individual cannot follow a state law and a federal law at the same time, the federal law is the supreme clause.¹³⁵ Based on this, the court held

130. *Id.* at *8–14. Under impossibility preemption, it would be impossible for one to simultaneously comply with both federal and state regulations; under obstacle preemption, a state law poses an obstacle to the accomplishment of federal goals. *Id.* at *8.

131. As one example, the court looked at ectopic pregnancies, a potentially fatal condition that makes up approximately 2% of pregnancies and which all parties agreed would be resolved through an abortion procedure. See *United States v. Idaho*, 623 F.Supp.3d 1096, 1104 (D. Idaho 2022) (noting that “the parties do not dispute” the appropriate treatment.). Under EMTALA, an ectopic pregnancy and a variety of other conditions clearly qualify as “emergency medical conditions.” CMS, *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss*, QSO-22-22-Hospitals (updated July 2022) (“Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy[.]”). However, in a wide variety of circumstances, including ectopic pregnancies, a treating physician would be hard pressed to know whether the pregnant person faced death. Lisa H. Harris, M.D. Ph.D., *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of Roe v. Wade*, 386 THE NEW ENG. J. OF MED. 2061–64 (June 2, 2022). The condition is clearly serious, and could lead to death, but the pregnant person could survive, albeit with serious consequences, such as amputations, infertility, or sepsis. ACOG, *Ectopic Pregnancy*, FAQ 155 (last reviewed July 2022) (noting that as an ectopic pregnancy grows, it can rupture and cause major internal bleeding); see also Yasmin Harisha, *Mom has Nearly all her Limbs cut off After Doc Failed to Spot Deadly Disease*, NEW YORK POST (March 11, 2018).

132. See *Idaho*, 623 F.Supp.3d at 1104–05 (noting several specific pregnancy-related conditions that EMTALA would require Idaho physicians to provide timely abortions for before the patients decompensate).

133. See *Idaho*, WL 3692618, at *13.

134. *Idaho*, 623 F.Supp.3d at 1102 (stating that “the drafters of our Constitution had the wisdom to provide a clear answer” to question of EMTALA v. Idaho state law). The Supremacy Clause provides “This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.” U.S. CONST. art. VI, § 1, cl. 2.

135. *Oneok v. Learjet, Inc.*, 575 U.S. 373, 377 (2015).

that the state of Idaho was 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.”¹³⁶ The court noted that the applicable affirmative defense section of the Idaho statute did not change the outcome for two reasons. First, because it only applied when a physician determined an abortion was “necessary” to prevent death, and (as discussed herein) EMTALA’s mandate is broader, thus leaving a swath of cases where the affirmative defense would not be available.¹³⁷ Second, the court noted the difference between an affirmative defense and an exception and found that the uncertainty therein also operated to frustrate EMTALA’s stated goal.¹³⁸

Thus, at least at the preliminary injunction stage, two different federal district courts issued conflicting conclusions as to whether EMTALA preempts a state anti-abortion scheme.¹³⁹

VIII. TEXAS V. IDAHO: WHOSE RIGHTS MATTER MOST?

While the decisions in *United States v. Idaho* and *Texas v. Becerra* merit a comparative analysis on their own, I note that there is an intervening additional Idaho state supreme court decision, *Planned Parenthood v. Idaho*,¹⁴⁰ with

136. *Idaho*, 2022 WL 3692618 at *15.

137. *Idaho*, 623 F.Supp.3d at 1109 (stating that, under “the plain language of the statutes ... EMTALA requires abortions that the affirmative defense would not cover.”).

138. An affirmative defense can be asserted where a justifiable crime occurs, and an exception means that no crime has occurred. *See Idaho*, 2022 WL 3692618 at *8–10. The district court was particularly troubled by the fact that the state had no exceptions at all, only affirmative defenses. *See id.* at *8–9 (“An affirmative defense is an excuse, not an exception.”). The court noted that having an affirmative defense rather than an exception increases the obstacle to EMTALA. *Id.* at 9, 12 (“[T]he affirmative defense is an empty promise[.]”).

139. The following month, in September 2022, the State of Idaho and the Idaho Legislature both filed motions for reconsideration in the case, which the government opposed in October. The Legislature’s motion can be accessed here, Idaho Legislature’s Motion for Reconsideration of Order Granting Preliminary Injunction https://storage.courtlistener.com/recap/gov.uscourts.idd.50547/gov.uscourts.idd.50547.97.0_1.pdf; the State’s motion can be accessed here: https://storage.courtlistener.com/recap/gov.uscourts.idd.50547/gov.uscourts.idd.50547.101.0_1.pdf; and the U.S. Government’s response can be accessed here: <https://www.justice.gov/file/1542166/download>.

140. *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132 (Idaho 2023) [hereinafter *Planned Parenthood*].

significant potential impact for that state's EMTALA litigation.¹⁴¹ In the *Planned Parenthood* decision, the Idaho Supreme Court upheld the state's anti-abortion laws. The court found that despite the plain language of the statute, not all abortions were actually banned, as the Idaho legislature did not really mean to outlaw abortions in the case of certain fetal anomalies.¹⁴² In addition, while acknowledging that it would be impossible for a provider to abide by the terms of the affirmative defense as written, where it mandated that abortions proceed while attempting to preserve fetal life, the court managed to save the statute by reading legislative intent into the law.¹⁴³ After holding that the legislature also meant the

141. Approximately five months after the federal district court issued its injunctive order, and while cross motions for reconsideration were pending, the Idaho Supreme Court issued its ruling in a consolidated group of cases that had been filed to directly challenge the state's anti-abortion laws. *Id.* Following a state-based originalism theory, the court's majority, in a 3-2 decision, held that because the framers of the state constitution did not intend to include a right to abortion in the document, such a right was not fundamental and therefore laws addressing the subject were not subject to a strict scrutiny analysis. *Id.* at 1188. Note that while the three opinions in the case—the majority and two dissents—all purported to start with the language of the state constitution, all reached different conclusions. See generally, Lawrence B. Solum, *What is Originalism? The Evolution of Contemporary Originalist Theory*, 47 GEO. UNIV. L. CTR. 741 (2011); Jeremy Telman, *Originalism as Fable (Reviewing Eric Segall, Originalism as Faith)*, 47 HOFSTRA L. REV. 741 (2018).

142. The court stated that the Idaho's legislature's goal was not actually to ban all abortions, but to ban abortions where there was "some chance of survival outside the womb." *Planned Parenthood*, 522 P.3d at 88 (emphasis in original). The court then held that the Idaho legislature actually did not mean what it had clearly said, and that ectopic or other non-viable pregnancies would not fall under the state's Total Abortion Ban definition of pregnancy, which meant that removing those fetuses would not be abortions, and providers would not be liable. (Note that non-viable pregnancies do not include issues involving the health of the pregnant person that do not pose an immediate risk to them but that will threaten their health or fetal health in the future, including treatment for cancer, see Jamie Abrams, *What Moving from Kentucky to Virginia After I Was Diagnosed With Cancer Reveals About Roe*, NBC News (July 7, 2022), <https://www.nbcnews.com/think/opinion/end-of-roe-kentucky-virginia-divergent-health-care-systems-for-women-rcna37215>). The Idaho Supreme Court noted that it could not use the same judicial construction to save Idaho's other abortion proscriptions, because those laws had differing definitions of pregnancy. See *Planned Parenthood*, 522 P.3d at 1203 (noting that neither the state's six-week abortion ban nor its civil liability law contain a definition of "pregnancy" like the one in the total abortion ban). Nevertheless, the court also carved ectopic and non-viable pregnancies out of the orbit of those laws by holding that those same conditions automatically constituted "medical emergencies" such that those laws also would not apply. See *id.* (where the court applied a "limiting judicial construction" to reach that conclusion).

143. The court noted it would be impossible for a provider to perform an abortion "in the manner that ... provides the best opportunity for the unborn child to survive" as an abortion, by definition, is intentional pregnancy termination. *Planned Parenthood*, 522 P.3d at 91–92. While the court agreed that a plain reading of the language was problematic, the court held that the legislature's "apparent attempt"

requirements of the affirmative defense to be read subjectively, the court upheld the bans in their entirety.¹⁴⁴

After the *Planned Parenthood* decision was issued by the Idaho Supreme Court in January 2023, the office of the newly elected Idaho Attorney General¹⁴⁵ asked the Idaho federal district court not to issue a decision in the EMTALA case, and for permission to file supplemental briefing based on the Idaho Supreme Court's decision.¹⁴⁶ The Idaho legislature joined in this request.¹⁴⁷ These motions stated, *inter alia*, that (a) the Idaho Supreme Court's decision to take abortions done because of ectopic and other non-viable pregnancies out of the realm of criminal activity and (b) its holding that § 18-622 does not actually mean that a pregnant person's death needs to be objectively immediate, meant that all assertions otherwise were erroneous and that the federal court had to rely on the

was actually "to protect the life of the unborn child *where it is possible.*" *Id.* at 92 (emphasis in original). Because it may or may not be possible to preserve fetal life while performing an abortion in a possible affirmative defense situation, the court upheld the ban. *Planned Parenthood*, 522 P.3d at 92. On September 21, 2022, the state of Idaho filed a motion for reconsideration of the court's preliminary injunction decision. State of Idaho's Motion to Consider Preliminary Injunction (Dkt. 95), United States v. Idaho, No. 1:22-CV-329 (D. Idaho Sept. 21, 2022), https://storage.courtlistener.com/recap/gov.uscourts.idd.50547/gov.uscourts.idd.50547.101.0_1.pdf.

144. *Planned Parenthood*, 522 P.3d at 10, 89–91. The court held, *inter alia*, that any worry over how imminent a pregnant person's death had to be for an affirmative defense to be asserted was not the appropriate question to be asking, as the legislature clearly meant the question to be answered subjectively. *Planned Parenthood*, 522 P.3d at 89 ("The plain language ... leaves wide room for the physician's 'good faith medical judgment' on whether the abortion was 'necessary to prevent the death of the pregnant woman' based on those facts known to the physician at that time."). Without the necessity of an objectively reasonable standard the court held that there is no necessary percentage threshold of the chance of patient death that a physician must ascertain before terminating a pregnancy, and therefore the state's anti-abortion laws actually gave physicians greater protections than they had before abortion was legalized under *Roe v. Wade*. *Planned Parenthood*, 522 P.3d at 11 ("This allowance of a defense based on the subjective 'good faith medical judgment' of the physician, coupled with the inclusion of rape and incest defenses, actually provides physicians with greater protections than the pre-*Roe* laws.").

145. On November 8, 2022, Raúl Labrador won the general election, garnering 62.6% of the vote, to become the 33rd Attorney General of Idaho. See *Idaho Attorney General Election, 2022*, BALLOTPEdia, https://ballotpedia.org/Idaho_Attorney_General_election,_2022 (last visited Mar. 27, 2023).

146. In this author's opinion, neither the state of Idaho nor the Idaho legislature presented any arguments of merit for reconsideration prior to their supplemental filings.

147. The Legislature's Joinder in the State of Idaho's Request for Permission to File Supplemental Briefing, dkt. # 119, and Motion to Stay Issuance of a Decision, dkt. # 120, United States v. Idaho (2023) (No. 1:22-cv-00329-BLW), 2022 WL 3692618, <https://storage.courtlistener.com/recap/gov.uscourts.idd.50547/gov.uscourts.idd.50547.121.0.pdf>.

state supreme court's interpretation of the law.¹⁴⁸ The United States responded in February 2023.¹⁴⁹

With the Idaho Supreme Court decision and its possible impact on the Idaho EMTALA case laid out, I turn now to the district courts at issue. As an initial matter I note that it is likely that lawsuits over EMTALA (and other federal laws) will proliferate, as it remains a generally open question as to how already existing federal law will interact with varying state restrictions on abortion. In fact, the U.S. Supreme Court currently has before it another case that calls into question the amount of deference due agency decisions.¹⁵⁰ As numerous courts will continue to entertain these challenges,¹⁵¹ it behooves us to examine what accounts for the differing conclusions in the Idaho and Texas EMTALA cases and how these cases can shed light on what the future holds.¹⁵² While there are myriad aspects of the

148. *Idaho*, 2023, WL 3692618.

149. United States' Supplemental Brief in Opposition to the Motions for Reconsideration, United States v. Idaho (2023) (No. 1:22-cv-329-BLW), 2022 WL 3692618, https://storage.courtlistener.com/recap/gov.uscourts.idd.50547/gov.uscourts.idd.50547.130.0_1.pdf.

150. That case is *Loper Bright Enterprises v. Raimondo*, No. 22-451. The U.S. Supreme Court granted certiorari on May 1, 2023 (Justice Jackson taking no part) on one of the two questions presented: "Whether the Court should overrule *Chevron* [*Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984)] or at least clarify that statutory silence concerning controversial powers expressly but narrowly granted elsewhere in the statute does not constitute an ambiguity requiring deference to the agency." (Parenthetical added.) The case will be argued in the Court's 2023-2024 calendar. At least one *amicus curiae* brief in the case is relying on the *Becerra* Court's reasoning. See Motion for Leave to File Brief as Amicus Curiae and Brief of Christian Employers Alliance as Amicus Curiae Supporting Petitioners, *Loper Bright Enters. v. Raimondo* (2023) (No. 22-451).

151. Both the Idaho and Texas federal district courts found the matters appropriately before them, as the plaintiffs had each established standing and neither court took issue with the Medicare-funding-in-exchange-for-EMTALA-compliance bargain as a general matter. See *Becerra*, No. 22-451 at 21-29 (holding that "Texas has sufficiently pled an actual injury to its sovereign interests"); *United States v. Idaho*, 2022 WL 3692618 at 16 (holding "the United States thus has established standing."). In Texas, the court held that the state's alleged injury to its sovereign interest was based on the court's belief that the HHS July memorandum, not the EMTALA statute itself, could be an impermissible expansion of federal authority that preempted and interfered with state law. *Becerra*, No. 22-451 at 1-2, 14-16. In Idaho, the court found that the federal government had sufficiently pled injury to its sovereign interest, that the harm alleged to the public's general welfare was properly redressed by the government, and that the U.S. was entitled to seek the benefit of its Medicare-funding-in-exchange-for-EMTALA-compliance bargain.

152. I note that another similarity in the opinions of the two courts was that they declined to entertain the "major questions" doctrine that both state legislatures had urged them to consider, on the theory that EMTALA spoke to the important and major policy question of abortion. *Becerra*, 2022 U.S.

decisions ripe for comparative analysis, this article focuses primarily on what I consider to be one of the most far reaching consequences of the *Texas v. Becerra* decision, one highlighted by juxtaposing that court's analysis with the one in *United States v. Idaho*—the rights of the fetus.¹⁵³

Dist. LEXIS 151142, at fn.11; Congressional Research Service, *EMTALA Emergency Abortion Care Litigation: Overview and Initial Observations* at 4 (Part II of II) (November 1, 2022). The major rules doctrine holds that agencies may not opine on issues of major economic and political significance unless Congress has provided a clear statement authorizing the agency to promulgate regulations in that area. See generally Michael Sebring, *The Major Rules Doctrine: How Justice Brett Kavanaugh's Novel Doctrine Can Bridge the Gap between the Chevron and Nondelegation Doctrines*, 12 N.Y.U. J. L. & LIBERTY 189 (2018). Although I find it unlikely that future courts would entertain this theory in the abortion realm, I expect legislative bodies seeking to preserve anti-abortion statutes in the face of EMTALA or other federal laws will continue to invoke it.

153. While this article focuses on the two federal district court EMTALA rulings and fetal personhood, I recognize that there are also a number of other important juxtapositions between the opinions, such as how each court viewed their states' abortion exceptions or affirmative defenses in relation to EMTALA's mandates. The courts' respective analysis on how the state laws at issue dovetail with or impede EMTALA's purpose is an issue of particular consideration. *EMTALA Emergency Abortion Care Litigation: Overview and Initial Observations (Part II)*, CONG. RSCH. SERV. (Nov. 1, 2022). Neither district court found a *per se* problem by virtue of the fact that EMTALA existed at the same time that there was a state law limiting abortion; instead, both district courts had to determine if there was in fact a conflict between EMTALA and the state law at issue. More specifically, both courts looked at the exceptions or affirmative defenses in the relevant state laws to determine if they frustrated EMTALA, thereby prompting a preemption analysis. The Idaho court looked at EMTALA much more broadly than the Texas court, holding that Congressional intent was to provide a baseline of emergency care to everyone presenting at an emergency department. *United States v. Idaho*, No. 1:22-cv-00329-BLW, 2022 U.S. Dist. LEXIS 153174, at *25, *34 (D. Idaho Aug. 24, 2022). While the Texas court acknowledged that EMTALA was broad, it focused primarily on the statute's attempt to prevent patient dumping. *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 U.S. Dist. LEXIS 151142, at *5, *46 (D. Tex. Aug. 23, 2022). Of course, what guides the determination of whether a federal law preempts a state law is not the intent of the state legislature at issue—it is Congressional intent. *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (“Congressional intent is the sole guide in determining whether federal law preempts a state statute.”). As noted above, the relevant Texas anti-abortion law contains very narrow exceptions. Specifically, that exception covers situations in which the pregnant person “has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed[.]” See TEX. HEALTH & SAFETY CODE ANN. § 170A.002 (West 2022). The Idaho statute at issue contained no exceptions, but provided two affirmative defenses, one of which was similar to the Texas exception language. That affirmative defense stated that, if prosecuted, a physician could avail themselves of the defense, when “in his good faith medical judgment ... the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death

IX. THE ASCENDENCY OF FETAL PERSONHOOD

The idea of fetal personhood, while legally tenuous, is a movement that has sought fertile ground since *Roe v. Wade* was decided.¹⁵⁴ The movement seeks incremental change in a long-term effort to normalize the idea that, from the moment of conception, developing embryos are entitled to the same rights and protections as living human beings.¹⁵⁵ Although efforts to legislate fetal personhood at the national level have not yet born fruit, as in many other instances, failure at the federal level moved proponents of fetal and embryonic personhood to the states.¹⁵⁶ At the state-level, efforts to establish fetal personhood directly did not fare well, so fetal personhood proponents have instead isolated areas in which to

of the pregnant woman because the physician believes that the woman may or will take action to harm herself.” (The Idaho statute also has an affirmative defense in cases of rape or incest, when the crime was reported to law enforcement and a copy of the report was provided to the physician.) See IDAHO CODE § 18-622 (2022). This is an important point, as all states seeking to ban or severely curtail abortion care have some limited exceptions or affirmative defenses written into their laws. Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*, NEW YORK TIMES (Jan. 21, 2023), <https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html>. The way these are written, and the extent to which they forbid abortion care in situations in which EMTALA arguably controls, is an analysis likely to repeat itself as litigation over these bans and the preemptive reach of EMTALA proliferates. Note that although only getting attention now, this problem actually predates *Dobbs*. In 2021, HHS sought to clarify EMTALA obligations under a Texas law forbidding abortions once fetal cardiac activity could be detected. See *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Sept. 17, 2021), [chrome-extension://efaidnbmnnnibpcajpcgclefindmkaj/https://www.mhanet.com/mhaimages/Regulatory/QSO-21-22-Hospitals.pdf](https://www.mhanet.com/mhaimages/Regulatory/QSO-21-22-Hospitals.pdf) (note that law was allowed to take effect during the pendency of the *Dobbs* case).

154. The first “Human Life Amendment” seeking to define a human being from the “moment of conception,” was introduced eight (8) days after the *Roe* decision in 1973. See H.R.J. Res. 261, 93rd Cong. (1973). This was the first of over 300 such resolutions, only one of which made it to a floor vote. Pooja Salhotra, *Does a Fetus Count in the Carpool Lane? Texas’ Abortion Law Creates New Questions About Legal Personhood*, TEX. TRIB. (Sept. 13, 2022). Note that the *Roe* opinion specifically noted that the word “person” was not defined as a fetus, and, if it were, the case would have to be differently decided. *Roe v. Wade*, 410 U.S. 113, 157 (1973).

155. There is a concern that laws employing the term ‘from the moment of conception,’ could also be used to prohibit forms of birth control where an egg is fertilized but not allowed to implant. This would include copper T IUDs and Plan B. Olga Khazan, *Here’s Why Hobby Lobby Thinks IUDs Are Like Abortions*, THE ATLANTIC, (Mar. 12, 2014).

156. *The Personhood Movement*, PROPUBLICA, <https://www.propublica.org/article/the-personhood-movement-timeline> (last visited March 29, 2023) (timeline showing growth of fetal personhood efforts).

advance this narrative.¹⁵⁷ These endeavors began with laws said to protect the pregnant person, such as state level fetal homicide laws (currently on the books in thirty-eight states).¹⁵⁸ Incremental advancement to declaring embryos continued from there.¹⁵⁹ The next step was holding the pregnant person themselves liable for fetal conditions, beginning with laws holding pregnant people liable for drug use.¹⁶⁰ In the early aughts, Arizona began issuing birth certificates for stillborn births, a practice that has now spread to thirty-four states.¹⁶¹ The increasing number of state level recognitions of fetal personhood brought the issue back to Congress, which began to follow the lead of the states—starting with passage of a law making it a crime to harm a “child, who is in utero.”¹⁶² This in turn emboldened a number of

157. Note that several other areas of legal scholarship evaluate the idea of personhood in other contexts, such as animal rights and corporations. See, e.g., Steven Wise, *Chimps Have Feelings and Thoughts. They Should Also Have Rights*, TED (March 2015), https://www.ted.com/talks/steven_wise_chimps_have_feelings_and_thoughts_they_should_also_have_rights?language=en; Ciara Torres-Spelliscy, *The History of Corporate Personhood*, THE BRENNAN CTR. (Apr. 8, 2014), <https://www.brennancenter.org/our-work/analysis-opinion/history-corporate-personhood>.

158. *Who Do Fetal Homicide Laws Protect? An Analysis for a Post-Roe America*, PREGNANCY JUST., (Aug. 17, 2022) (providing an overview of fetal homicide laws nationwide as of August 2022).

159. These laws referenced punish pregnant people for their pregnancies and for their autonomous behavior within pregnancy, by granting the fetus rights separable from the pregnant person. Under this legal framework, the interests of one legal person (the fetus or embryo or zygote) are being harmed by another legal person (the pregnant person). This means that the fetus and the pregnant person are in a potentially hostile relationship and that the pregnant person can be liable for harm to another legally identifiable person, the fetus. See, e.g., Melissa Gira Grant, *The Growing Criminalization of Pregnancy*, THE NEW REPUBLIC (May 5, 2022), <https://newrepublic.com/article/166312/criminalization-abortion-stillbirths-miscarriages>; Lisa Harris & Lynn Paltrow, *The Status of Pregnant Women and Fetuses in US Criminal Law*, 289 JAMA 1697 (2003).

160. *Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992) (overturning pregnant person’s conviction for ‘delivering’ cocaine via her umbilical cord, as the criminal statute at issue showed no intent to use the word ‘delivery’ in such a manner); *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980) (considering prenatal maternal drug use when determining neglect of a living child). The states continued to extend their reach, and in 2014 Tennessee enacted a temporary state law holding that pregnant drug users faced up to fifteen years in jail. After two years the law was allowed to lapse. See Nina Liss-Schultz, *Tennessee’s War on Women is Sending New Mothers to Jail*, MOTHER JONES (Mar. 14, 2016), <https://www.motherjones.com/politics/2016/03/tennessee-drug-use-pregnancy-fetal-assault-murder-jail-prison-prosecution/>. Also note that prosecutions against pregnant people under fetal protection laws are more commonly brought against poor and black, indigenous, and other people of color. Vanessa Vecchiarello, *The Criminalization of Pregnancy and Its Effects on Maternal Health: Understanding State Interventions*, 47 FORDHAM URB. L. J. 1051, 1053–54, 1064–65 (2020); Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CAL. L. REV. 781, 873 (2014).

161. ARIZ. REV. STAT. ANN. § 36-330 (2022). The process for acquiring such a certificate is available online. *Certificate of Birth Resulting in Stillbirth*, ARIZ. DEP’T OF HEALTH SERVS. (Apr. 21, 2023).

162. Unborn Victims of Violence Act, 18 U.S.C. § 1841.

states on the issue. Measures more directly attempting to address the issue of fetal and embryonic personhood proliferated. For example, between 2008 and 2014, five state ballot measures that would give personhood to fetuses were introduced, although all were defeated by voters.¹⁶³ More recently, in 2021, the state of Arizona passed Senate Bill 1457, which was signed into law by then Governor Doug Ducey. The bill banned certain abortions¹⁶⁴ and conveyed personhood on fertilized eggs, embryos, and fetuses.¹⁶⁵ This personhood provision required that all Arizona statutes be interpreted to give fetuses, embryos, and fertilized eggs the same rights as birthed and living people.¹⁶⁶ The law was immediately challenged in court¹⁶⁷ and in July 2022, after the *Dobbs* decision was issued, the personhood provision was enjoined by the Arizona federal district court.¹⁶⁸ Legislators continue to advance bills attempting to endow personhood on embryos beginning at the moment of conception.¹⁶⁹ In the current 2022-2023 legislative session, the Missouri legislature is considering House Bill 167, which would give “unborn children . . . the same rights

163. See *History of Abortion Ballot Measures*, BALLOTPEDIA, https://ballotpedia.org/History_of_abortion_ballot_measures#Personhood_amendments (last accessed March 23, 2023). Three of these were in Colorado: Amendment 67 (2014), Initiative 62 (2010), and Initiative 48 (2008). *Id.* Another, Initiative 26, was in Mississippi (2011), and Measure 1 was in North Dakota (2014). *Id.* There had also been one earlier effort, Question 14, in Rhode Island (1986). *Id.*

164. One part of the bill, the Reason Ban, prohibited abortions when the physician knew that the termination was desired because of a genetic abnormality. See ARIZ. REV. STAT. ANN. §§ 13-3603.02, 36-2157 (2018). This ban also had a reporting requirement. See ARIZ. REV. STAT. ANN. §§ 36-2158(A)(2)(d), 36-2161(A)(25) (2018).

165. See ARIZ. REV. STAT. ANN. § 1-219 (2021).

166. *Id.*

167. *Isaacson v. Brnovich*, 563 F. Supp. 3d 1024 (D. Ariz. 2021). The plaintiffs sought a preliminary injunction prior to the law taking effect. *Id.* at 1029. The court denied that request as to the personhood provision, which the plaintiffs appealed. *Id.* at 1047. Because of the procedural history of the case, the court looked at the case before it as a renewed motion for a preliminary injunction. *Id.* at 1254–55.

168. *Isaacson v. Brnovich*, 610 F. Supp. 3d 1243, 1257 (D. Ariz. 2022). In finding the personhood rule of statutory construction unconstitutionally vague, the court held that when the “dust settle[d]” around the status of abortion in Arizona, even under the strictest of the possible laws contemplated, some abortions would be legal. *Id.* at 1254. If the personhood rule of statutory construction were to stand, abortion providers would likely be liable under some Arizona laws newly interpreted to accord an embryo the same rights as an individual, but they would have no way of knowing exactly what laws that would be. *Id.* at 1254–55.

169. Note that other cases, pre-*Dobbs*, have also assessed the idea of fetal personhood in the context of abortion. See, e.g., *SisterSong Women of Color Reprod. Just. Collective v. Kemp*, 472 F. Supp. 3d 1297, 1328 (N.D. Ga. 2020) (enjoining a law defining personhood to include an “unborn child” on vagueness grounds); *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 506–07 (1989) (holding that a section of Missouri law stating that life begins at conception could be read as a preamble unripe for a substantive due process challenge). Note that after the *Webster* decision, the state supreme court read this preamble as a valid canon of interpretation. See *Connor v. Monkem Co., Inc.*, 898 S.W.2d 89, 92 (Mo. 1995).

. . . as are secured . . . to any other human person.”¹⁷⁰ And the Ohio legislature is considering House Bill 704, which would recognize personhood as beginning at the moment of conception.¹⁷¹

During the *Dobbs* oral argument, several Justices indicated that they saw the issue as implicating more than just the right to abortion currently before them.¹⁷² And the *Dobbs* majority opinion seems to speak on both sides of the issue of fetal personhood. On one hand, the majority stated that their opinion “[was] not based on any view about if and when prenatal life is entitled to any of the rights enjoyed after birth.”¹⁷³ Then the Court stated that nothing in the Constitution required the conclusion that a fetus lacked all human rights, primarily the right to life, before birth.¹⁷⁴ And throughout the opinion the Court repeatedly referred to embryos and fetuses as “unborn human beings.”¹⁷⁵

Thus, while using the legal term “person” to apply to embryos and fetuses in a wide variety of circumstances has been making its way through multiple states on multiple fronts for quite some time,¹⁷⁶ *Dobbs* was a big advancement in the march toward fetal personhood, and the *Becerra* decision was an additional step.¹⁷⁷ The *Dobbs* dissent clearly saw where the majority was leading on personhood, noting the decision meant that “from the very moment of fertilization, a woman has no rights to speak of.”¹⁷⁸ This is because declaring an entity a person from the moment

170. See H.B. 167, 102nd General Session (Mo. 2022).

171. See H.B. 704, 134th General Assembly (Ohio 2022).

172. Justice Thomas specifically said that his question was not about abortion, but about any rights in bodily autonomy held by the pregnant person when engaging in a behavior that would harm the fetus. Transcript of Oral Argument at 50, *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022) (No. 19-1392). Justice Alito asked counsel for both sides about the rights of personhood beginning at conception and not at viability, implying that viability could be the factor for personhood. *Id.* at 32, 66. Justice Barrett said that the imposition on the autonomy of the pregnant person in forcing them to remain pregnant was lessened where they could avail themselves of safe haven and adoption choices post-pregnancy. *Id.* at 56, 58.

173. *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2256 (2022).

174. *Id.*

175. *Id.* at 2284, 2254 fn.14.

176. See When Fetuses Gain Personhood: Understanding the Impact on IVF, Contraception, Medical Treatment, Criminal Law, Child Support, and Beyond, PREGNANCY JUST., (Aug. 17, 2022) (summarizing the myriad ways states have already accepted fetal personhood and the implications therein).

177. See Madeleine Carlisle, Fetal Personhood Laws Are a New Frontier in the Battle Over Reproductive Rights, TIME MAG. (June 28, 2022), <https://time.com/6191886/fetal-personhood-laws-ro-abortion/>; Editorial, A Woman’s Rights: Part 8: The Future of Personhood Nation N.Y.TIMES (Dec. 28, 2018), <https://www.nytimes.com/interactive/2018/12/28/opinion/abortion-law-pro-life.html>; *Texas v. Becerra*, 623 F. Supp. 3d 696, 726 (N.D. Tex. 2022).

178. *Dobbs*, 142 S. Ct. at 2317 (Breyer, J., Kagan, J., and Sotomayor, J., dissenting).

of conception threatens the rights and bodily autonomy of the pregnant person—and would also be in contravention of international norms.¹⁷⁹ In *Becerra* the rights of the fetus overtook the rights of the pregnant person at issue in the context of EMTALA.¹⁸⁰ This is, fundamentally, the heart of the problem.¹⁸¹

The *United States v. Idaho* court viewed EMTALA as a statute designed to medically stabilize the patient—the pregnant person. By perceiving the statute’s mandates as ones whose purpose is to screen and stabilize the pregnant person, the Idaho court looked with disfavor at laws that made addressing the pregnant person’s emergency medical conditions both less comprehensive and less timely.¹⁸² Because the District Court for the Northern District of Texas read EMTALA as a statute that is designed to protect the pregnant person and the fetus equally,¹⁸³ the court had no problem with a legislative decision to balance the two, or even to prefer the life of the fetus. In my opinion, the way each court viewed whose life the federal statute was designed to protect informed how willing they were to entertain state-level laws that prioritized fetal life as being equal or superior to maternal life.

In determining whether Congress had spoken to the issue in question, and therefore foreclosed state action, the Texas court framed the question thusly, “whether physicians must perform abortions when they believe that it would resolve a pregnant woman’s emergency medical condition, *irrespective* of the

179. Human rights protections under international law begin at birth. See Letter from Global Justice Center, et al., to United Nations, at p. 18, n.108, Mar. 2, 2023, (noting that rights under the International Declaration of Human Rights and under the Covenant on Civil and Political Rights are not applicable pre-birth).

180. The *Becerra* court read the lack of Congressional intent to permit the state of Texas to determine that fetal person rights prevailed in the EMTALA context. *Texas v. Becerra*, at 727–28. In future scenarios, fetal person rights can clash with the pregnant person’s right to elect surgery, undergo chemotherapy, play sports, drink alcohol, use IVF treatments, or engage in dangerous activities. The list is, frankly, endless.

181. Note that this discussion of legal fetal personhood is distinct from a recognition that a fetus has value. Protecting a fetus, and a pregnant person’s interest in that fetus, are laudable goals shared by the author and are not the subject of this article. This article focuses on EMTALA and its interaction with the concept of fetal personhood, a legally distinct definition that improperly separates the fetus from the pregnant person and attempts to accord them equal (and sometimes greater) rights. Not only is this a legal and philosophical conundrum it is a practical impossibility. The value of a fetus, embryo, or zygote cannot be a legal personhood value without subsuming the rights and freedoms of the pregnant person to the whims of changing legislatures, the politics of a doctor, and advancements in science.

182. *United States v. Idaho*, No. 22-cv-00329, 2022 WL 3692618 at *2 (D. Idaho Aug. 24, 2022).

183. *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 WL 3639525, at *20 (N.D. Tex. Aug. 23, 2022) (“[A] physician’s duty . . . applies equally to the pregnant woman and her unborn child.”).

unborn child's health and state law."¹⁸⁴ In answering that question, the Texas court found that EMTALA provided "no roadmap"¹⁸⁵ but felt that it could discern congressional intent to protect "the health of both[.]"¹⁸⁶ Because of this, the *Becerra* court determined that elevating the health of the pregnant person to the exclusion of the fetus was not a permissible statutory construction, and the HHS July memorandum impermissibly negated the physician's equal duty to the fetus in contravention of congressional intent.¹⁸⁷ Because the *Becerra* court held that the pregnant person and the fetus held equal positions, and because in such a case of competing interests, EMTALA does not specify how the emergency department provider should hierarchy the two interests, the court held that only doctors comporting within state law restrictions, such as Texas' anti-abortion statutes, could make that decision.¹⁸⁸

In contrast, the Idaho court did not read the language in EMTALA similarly, nor did it equate those interests equally.¹⁸⁹ That district court's opinion looks at the medical condition of the pregnant person presenting in an emergency department and what is in their medical best interest under EMTALA.¹⁹⁰ The Idaho court regularly refers to the "patient" at issue as the "pregnant patient" and does not entertain the notion that that the fetus of a pregnant person presenting with a medical emergency has an interest that can delay or prevent the treatment that would stabilize that pregnant person.¹⁹¹

As the Idaho court correctly read, under EMTALA, it is the pregnant person who has decided to present at a hospital emergency room, and it is they who are the patient. In other words, EMTALA provides for the rights of the fetus *via the*

184. *Id.* at *19 (emphasis in original).

185. *Id.* Note that in the case of a pregnant person experiencing contractions, the *Becerra* court noted that EMTALA required delivery. *Id.* at *20 n.12 (citing 42 U.S.C. § 1395dd(e)(3)). In *United States v. Idaho*, the court noted that the subsection relating to a pregnant person having contractions was not relevant to the issues presently before the court. *United States v. Idaho*, No. 1:22-cv-00329-BLW, 2022 WL 3692618, at *2 n.1 (D. Idaho Aug. 24, 2022).

186. *Becerra*, 2022 WL 3639525, at *22.

187. *Id.* at *18, *20.

188. *Id.* at *20–21. In *Texas v. Becerra*, HHS had argued that the EMTALA reference to the health of an unborn child was to address a situation in which the pregnant person's health was not threatened but the continued health of a wanted pregnancy is at risk, an interpretation the court found to be impermissible. *Id.* at *23–24.

189. Note that the decision in Idaho was issued the day after the decision in Texas, providing the Idaho court with an opportunity to review and incorporate any reasoning it found persuasive in the *Texas v. Becerra* opinion into its own analysis.

190. *Idaho*, 2022 WL 3692618, at *8 ("[W]hen 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.").

191. *Id.* at 1, 2, 7–10, 15, 19–21, 23, 24, 27–29, 33, 35–37, 39.

pregnant woman. No other interpretation makes sense, either from the statutory history or legally.¹⁹² This is the way the statute is written, and it is a recognition that while there is a legitimate interest in the welfare of the fetus, that interest is dependent upon and subject to the rights of the singular legal person in the emergency department: the pregnant person. HHS, the agency tasked with EMTALA oversight, agrees with this interpretation, holding that that pregnant persons are the patients presenting at emergency departments.¹⁹³ Specifically, it has said, “[N]othing . . . indicates that Congress intended to limit the EMTALA-mandated care to pregnant patients, or to require a provider to prioritize the fetus’s health[.]”¹⁹⁴ Thus, the correct lens required under EMTALA is that the presenting patient is the pregnant person and it is they who are federally entitled to the screening, stabilization, and transfer requirements of that statute. Under this directive, the EMTALA mandated screening reveals whether that patient has an emergency medical condition under the language of the statute. If they do not have such a condition, a hospital’s obligations under EMTALA are at an end. If they do have such a condition, they are entitled to stabilizing treatment or an appropriate transfer for their condition. By giving that pregnant person’s fetus agency, the Texas court has undercut EMTALA’s main purpose: to ensure that all *persons* presenting at emergency departments receive basic care.

Further, to the extent that the federal district court in Texas may have identified gaps in the interplay between EMTALA and its state’s anti-abortion scheme, its solution is incorrect.¹⁹⁵ The court held that if such a gap exists, the health of the pregnant person and the health of the fetus have to be equally balanced and that such balancing should be (and was in the case at issue) done by

192. See generally Lisette Ten Haaf, *Future Persons and Legal Persons: The Problematic Representation of the Future Child in the Regulation of Reproduction*, LAWS, (Feb. 2016), <https://ideas.repec.org/a/gam/jlawss/v5y2016i1p10-d64618.html> (explaining how an unborn child does not fit into any of the dominant theories on legal personhood, which all lack the vocabulary and conceptual structure to logically encompass such a theory).

193. Defendants’ Brief in Support of Their Motion to Dismiss and In Opposition to Plaintiffs’ Motion for a Temporary Restraining Order and Preliminary Injunction, *Texas v. Becerra*, 577 F.Supp.3d 527 (N.D. Tex. 2021) (No. 5:22-cv-00185-H), 2022 WL 4234701 at 25, 28; *United States v. Idaho*, No. 1:22-CV-00329-BLW, 2022 WL 3137290, 9, 10 (D. Idaho Aug. 2, 2022).

194. *The United States’ Mot. for a Prelim. Inj.* at 19, *United States v. Idaho*, 623 F. Supp. 3d 1096 (D. Idaho 2022).

195. It is unclear exactly where this gap truly lies. As HHS noted in its briefing (Dkt. 39 at 24) it is difficult to conceive of such a situation. However, the *Becerra* court found that an incomplete medical abortion—where a pregnant person presents at an emergency department after taking the first of two drugs to produce an abortion—could be a scenario within this gap. In that case, the court opined that the fetus might still be alive and the pregnant person not at risk of substantial impairment but may still qualify for an abortion under EMTALA guidance. *Becerra*, 2022 WL 3639525, at *16. Note that as states experiment with increasingly narrower exceptions, any gaps between EMTALA and state law may widen, particularly in mental health situations.

the state legislature.¹⁹⁶ I believe that that gap, should it exist, should be the decision of the pregnant person.¹⁹⁷ In fact, under EMTALA, patients are able to accept or refuse treatment as they see fit—a right that clearly rests with the pregnant person and not with a fetus.¹⁹⁸ The Texas court noted that abortion is not specifically mentioned as a procedure a pregnant person has a right to refuse,¹⁹⁹ but does not address the fact that the ability to accept or refuse medical services is a broad allowance that does not pick and choose between any services a patient may elect to allow or deny.

In addition, the *Becerra* ruling not only takes the decision to accept or deny treatment away from the presenting patient, it also impermissibly adds another step to the emergency room process, and such an imposition frustrates EMTALA's intent to provide sufficient and timely care to patients with emergency medical conditions.²⁰⁰ Under this new reading, providers cannot follow EMTALA's mandate to stabilize that patient. Instead, medical providers must now bring in a new set of considerations—how stabilizing the person presenting with an emergency medical condition might impact a pregnancy, thereby depressing what was once a clear right to treatment to a possible right to treatment.

Most critically, the *Becerra* court's reading of the statute is, in essence, giving personhood to the fetus in the EMTALA context.²⁰¹ This increased acceptance of fetal personhood is not only a legal problem, but also the cause of increasingly

196. *Becerra*, 2022 WL 3639525, at *54 (“EMTALA leaves that balancing to doctors, who must comply with state law.”).

197. One proposed solution to the problems with fetal personhood is the Fetal Maternal Identity Theory, which affords the fetus rights through and in relation to its mother. Amanda Gvozden, *Fetal Protection Laws and the “Personhood” Problem: Toward a Relational Theory of Fetal Life and Reproductive Responsibility*, 112 J. CRIM. L. & CRIMINOLOGY 409 (2022).

198. 42 U.S.C. § 1395dd(b)(2) (stating a presenting patient may “refuse[] to consent[.]”).

199. *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 U.S. Dist. LEXIS 151142, at *72 (D. Texas Aug. 23, 2022) (noting that the EMTALA provision allowing refusal of services “says nothing about abortion.”).

200. *United States v. Idaho*, WL 3692618 at *14 (As the Idaho court observed, “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.”).

201. Giving personhood to a fetus obviously impacts a variety of laws and situations outside EMTALA, including child support payments, tax deductions, and census tracts. As just one example, the *Dobbs* decision triggered a 2019 Georgia law, the Living Infants Fairness and Equality Act, which has since been interpreted to mean that fetuses qualify for dependent personal tax exemptions. Press Release, Georgia Dep't of Revenue, Guidance Related to House Bill 481, Living Infants and Fairness Equality (LIFE) Act (Aug. 1, 2022), <https://dor.georgia.gov/press-releases/2022-08-01/guidance-related-house-bill-481-living-infants-and-fairness-equality-life>; see also Salhotra, *supra* at note 154; Lydia Wheeler, *Fetal Rights Laws' Impact Extends From Abortion to HOV Lanes*, BLOOMBERG L. (July 27, 2022, 2:45 AM), <https://news.bloomberglaw.com/us-law-week/fetal-rights-laws-impact-extends-from-abortion-to-hov-lanes>.

negative realities in both states, particularly in the areas of maternal outcomes, physician retention, and EMTALA related complaints.²⁰² Maternal mortality is a particular problem in the United States, which had the highest maternal mortality rate of any developed country pre-*Dobbs*, and that rate is continuing to climb.²⁰³ And even within the context of America, Texas and Idaho do not fare well—Texas ranks 8th in the United States, with a maternal mortality rate of 34.5 and Idaho has a maternal mortality rate of 23.8.²⁰⁴ In recognition of this problem, both states instituted maternal mortality committees in order to gather data and recommend changes that would reduce maternal deaths—Texas in 2013 and Idaho in 2019.²⁰⁵ The Idaho Maternal Mortality Review Committee published a report that found, *inter alia*, the majority of pregnancy associated deaths were among Medicaid participants and reviewed the steps in establishing a state Perinatal Quality Collaborative to act on the Committee’s recommendations.²⁰⁶ The latest Texas Report was also published in 2022 and found, *inter alia*, that Black women, persons

202. While this article focuses on the way the two federal district courts used differing conceptions of fetal personhood in the EMTALA context, there are other notable ways in which the decisions vary. See Michelle M. Mello, *Resuscitating Abortion Rights in Emergency Care*, JAMA HEALTH F. (Sept. 8, 2022) (looking to account for the disparate decisions in the Idaho and Texas EMTALA lawsuits); Alicia Macklin, et al., *Between EMTALA and State Abortion Restrictions: The Post-Dobbs Dilemma*, HEALTH L. CONNECTIONS (Jan. 1, 2023), <https://www.americanhealthlaw.org/content-library/connections-magazine/article/b7a49aa7-ec78-48dd-b254-be04e2db46f7/between-emptala-and-state-abortion-restrictions-the> (reviewing the two decisions).

203. Munira Z. Gunja, et al., *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison*, THE COMMONWEALTH FUND (Dec. 1, 2022), <https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison>. In 2020, the U.S. maternal mortality rate was over three times that found in other developed nations—24/100K live births. The rate was 55/100K for Black women. *Id.*

204. *Maternal Mortality Rate by State 2023*, WORLD POPULATION REV., <https://worldpopulationreview.com/state-rankings/maternal-mortality-rate-by-state> (last visited Apr. 10, 2023).

205. See IDAHO CODE §§ 39-9601-06 (2019); Texas S. B. 750, 86R (2019). Note that Idaho’s work had an end (or “sunset”) date of July 2023. IDAHO CODE § 39-9601. In an effort to continue the work of the committee, House Bill 81 was introduced in the 2023 Idaho legislative session. As of this writing that bill is in the Health and Welfare Committee and its passage thus far unknown. See *2023 Legislation, House Bill 81*, IDAHO LEGISLATURE, <https://legislature.idaho.gov/sessioninfo/2023/legislation/H0081/>; Nick Thomas, *Idaho Becomes 1st State Without Formal Maternal Death Review Process*, BECKER’S HOSP. REV. (July 12, 2023).

206. Idaho Dep’t of Health and Welfare Maternal Mortality Rev. Comm., *Maternal Deaths in Idaho 2020* (2020) https://www.idmed.org/idaho/UploadedFiles/2020IdahoMMReport_FINAL.pdf.

without private health care coverage, with less education, and of advanced age continued to experience the highest rates of pregnancy related mortality.²⁰⁷

One possible reason for this increased maternal mortality rate is the practice of ‘observed decompensation’ of a pregnant person in crisis, where a health professional in a state that restricts abortion allows a pregnant person to deteriorate until they either improve spontaneously or get close enough to death to warrant abortion care.²⁰⁸ While reporting requirements differ, news stories of delayed care are increasingly finding their way into the news.²⁰⁹ In fact, in Texas, the first study comparing mortality rates of pregnant people presenting with complications before and after implementation of the state’s anti-abortion laws has shown a worrying increase in maternal mortality.²¹⁰ This is because under state law, Texas physicians at the two hospitals studied had to wait before intervening in specific pregnancy complications, raising the maternal mortality rate to 57%.²¹¹ Even more recently, five Texas women—along with two OB/GYNs—filed suit against the state, claiming that they were denied medically necessary abortion care and seeking clarification as to when exactly abortions are medically permissible under state law.²¹² Four of the women had to travel out of state for abortion care

207. Tex. Dep’t of State Health Servs., Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022 (Dec. 2022) <https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Joint-Biennial-MMMRC-Report-2022.pdf>.

208. Ethics Talk Series on US Abortion Care After Dobbs: Wait. What? Some Clinicians Agree to Watch Their Patients Get Sicker? AMA J. ETHICS (Jan. 24, 2023), <https://edhub.ama-assn.org/ama-journal-of-ethics/audio-player/18752126>; see also Elyssa Spitzer et al., Abortion Bans Will Result in More Women Dying, CTR. FOR AM. PROGRESS (Nov. 2, 2022) <https://www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying/> (noting specific instances where pregnant people had delayed care because of state imposed restricted abortion access).

209. Stephanie Emma Pfeffer, *Texas Woman Nearly Loses Her Life After Doctors Can’t Legally Perform an Abortion: ‘Their Hands Were Tied’*, PEOPLE (Oct. 18, 2022, 11:59 AM), <https://people.com/health/texas-woman-nearly-loses-her-life-after-doctors-cannot-legally-perform-abortion/> (reporting the story of a Texas woman who became septic after Texas doctors had to wait to abort her miscarriage).

210. Anjali Nambiar MD 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, 227 AM. J. OF OBSTETRICS & GYNECOLOGY, 648, 649 (2022) (comparing a maternal morbidity rate from states without such restrictive legislative is 33%).

211. *Id.*

212. Brief of Plaintiffs at 1–2, *Zurawshi v. Texas*, No. D-1-GN-23-000968 (Tex. Dist. Ct. Mar. 6, 2023). Note that after the case was filed the complaint was amended and eight additional plaintiffs were added (see amended complaint at <https://reproductiverights.org/wp->

and the fifth was sent home to medically decompensate until her condition warranted an abortion.²¹³ Her claim is that the state-mandated delay was the cause of a permanent fallopian tube closure that will make future pregnancies more difficult.²¹⁴

Physician exodus is another on-the-ground worry in states increasingly seeking to hold doctors criminally liable for providing standard of care compliant medical attention.²¹⁵ In Idaho, the district court acknowledged the risk that doctors facing charges for practicing medicine would lead to an exodus of qualified personnel.²¹⁶ This risk is already becoming a reality.²¹⁷ Additionally—while EMTALA complaints are generally not public—there is both confirmed and anecdotal evidence suggesting that EMTALA complaints against hospitals and physicians in abortion restricted states are climbing, with the subjects of those complaints at risk

content/uploads/2023/05/2023.05.22-Zurawski-v.-Texas-1st-Am.-Ver.-Pet.-FINAL.pdf. In August 2023 the court granted the plaintiffs' motion for injunctive relief (*see* https://reproductiverights.org/wp-content/uploads/2023/08/Zurawski-v-Texas_TI.pdf); however, the injunction was blocked by an appeal to the Texas Supreme Court.

213. *Id.*

214. *Id.* at 1.

215. Nicole Karlis, *Strict Abortion Laws are Driving an Exodus of Women's Health Specialists*, SALON (June 30, 2023); Arielle Dreher & Oriana Gonzalez, *New Doctors Avoid Residencies in States with Abortion Bans*, AXIOS (Apr. 18, 2023); Poppy Noor, *The Doctors Leaving Anti-Abortion States: 'I Couldn't do my Job at All'*, THE GUARDIAN (Oct. 26, 2022). Speculation over how far legislatures can go in attempting to regulate behaviors they disapprove of by threatening medical doctors with criminal liability is rife. For example, one article posits that legislatures with the power that Texas is trying to assert “could attempt to deter driving while intoxicated by barring clinicians from providing care after a motor vehicle crash unless the intoxicated person's life is in danger.” Sara Rosenbaum et al., *Will EMTALA Be There for People With Pregnancy-Related Emergencies?*, 387 NEW ENG. J. OF MED. 863, 865 (Sept. 8, 2022) (noting that the Texas court misread a provision of the Social Security Act).

216. *United States v. Idaho*, 1:22-cv-00329-BLW, 2022 WL 3692618, at *13 (“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.”).

217. Kylie Cooper, *I Came to Provide Care for Complicated Pregnancies; I'm Leaving Because of Idaho's Abortion Bans*, IDAHO CAP. SUN (Feb. 10, 2023), <https://idahocapitalsun.com/2023/02/10/i-came-to-provide-care-for-complicated-pregnancies-im-leaving-because-of-idahos-abortion-bans/>. In March 2023, after a leading OB/GYN announced she was leaving Idaho due to the state's continued criminalization of medical procedures such as abortion, the medical facility at which she worked announced it would be closing its labor and delivery unit entirely, reducing critical services in the Sandpoint region of the state. Kelcie Moseley-Morris, *Idaho Hospital to Stop Delivering Babies. One Reason? 'Bills that Criminalize Physicians'*, IDAHO STATESMAN (Mar. 17, 2023), <https://www.idahostatesman.com/living/health-fitness/article273303190.html>.

of the penalties detailed previously.²¹⁸ In one case, a woman filed an EMTALA complaint alleging that hospitals in Missouri and Kansas denied her the emergency abortion care she needed at week eighteen of her pregnancy.²¹⁹

X. Conclusion

The Supreme Court's decision in *Dobbs* assured that legal questions around the availability of abortion care will continue to be litigated for years to come, especially where federal law ostensibly clashes with state restrictions. In this context, states asserting power to limit EMTALA protections to only acceptable emergency medical services—even when a hospital's response is grounded in nationally accepted standards of medical care—ignore the supremacy clause and endanger the life of the actual patient presenting: the pregnant person. In essence, EMTALA is the latest battleground in a struggle over more than the right to an abortion. The *Becerra* court, against relevant agency interpretation, read a gap into EMTALA and allowed that gap to be filled by state law promoting the ascendancy of the rights of zygotes, embryos, and fetuses over the rights of the pregnant person. That reading comes at a cost, and that cost is born entirely by the pregnant person.

218. *Post Dobbs Fallout Tracker—Feds Say Two Hospitals That Denied Emergency Abortion Broke the Law*, FIERCE HEALTHCARE (May 2, 2023) <https://www.fiercehealthcare.com/providers/post-dobbs-fallout-tracker-kan-voters-resoundingly-reject-abortion-ban>. In addition to the publicly addressed cases, this author is aware of a number of alleged EMTALA violations currently being investigated. *Id.*

219. Administrative Complaint at 3, Mylissa Farmer v. Freeman Health System (Nov. 8, 2022) <https://nwlc.org/wp-content/uploads/2022/11/2022.11.08-Mylissa-Farmer-EMTALA-complaint.pdf> (expressing reservations about having one of CMS's regional offices investigating her complaint and requested an independent investigation of her claim).