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EMTALA Preemption of State Laws Restricting Emergency Abortions

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EMTALA PREEMPTION OF STATE LAWS RESTRICTING EMERGENCY ABORTIONS

ABSTRACT

The Emergency Medical Treatment and Labor Act (EMTALA) was established to restrict hospitals from refusing to treat or transferring patients with an unstable emergency medical condition. While intended to protect vulnerable groups from discrimination, the duty EMTALA imposes on hospitals also applies when a pregnant patient presents to a participating emergency room experiencing an emergency medical condition where the standard of care is pregnancy termination. Since Dobbs v. Jackson Women's Health Organization*, states have enacted laws prohibiting abortions, many with no exception or exceptions too narrow for stabilizing a pregnant patient's emergency medical condition as required by EMTALA. This Note examines the history of EMTALA and current state laws restricting abortion in Idaho, Texas, Missouri, Arkansas, and Alabama. This Note discusses how those state laws are at risk of being preempted to the extent of conflict by EMTALA's express preemption clause, which preempts any state law that "directly conflicts" with the requirements of the Act. State laws that make it (1) impossible to comply with the requirements of EMTALA or (2) those laws that stand as an obstacle to the Act are at risk of preemption. A state law that only permits an abortion when the pregnant person's life is at risk directly conflicts with EMTALA's requirement to stabilize an emergency condition and to prevent material deterioration of the condition. Obstacles to EMTALA may include a state law that imposes additional requirements on a hospital prior to providing the stabilizing care, heavy burdens on a provider such as criminal penalties requiring an affirmative defense or those that chill their response to the condition, or unclear or narrow definitions of statutory terms. Finally, this Note concludes that state laws restricting emergency abortions that do not adopt the statutory language of EMTALA for the stabilization of an emergency medical condition are at risk of being preempted to the extent of the conflict.*

I. INTRODUCTION

Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 in response to reports about emergency departments refusing to treat patients who could not pay for care.[1] When a patient presents to an emergency department that participates in Medicare or Medicaid, EMTALA imposes a duty on that emergency department to (1) screen the patient for an emergency medical condition,[2] and (2) if an emergency medical condition exists, to stabilize the medical condition before transferring or discharging the patient, unless certain conditions are met.[3] Further, in 1989, Congress expanded EMTALA to include a duty on emergency departments to accept "appropriate" transfers.[4]

EMTALA is commonly known as the Patient "Anti-Dumping" Act because of the congressional intent to prevent hospitals from "dumping" poor or uninsured patients, either by refusing to provide them care or transferring them before they are stabilized.[5] However, EMTALA is not limited to people who do not have the resources to pay, but rather applies to *any* individual presenting to the emergency department.[6] The Act imposes a legal duty on hospitals to provide emergency medical care to all patients, within the medical capabilities of the hospital, to protect patients who might otherwise go untreated or left without a legal remedy and to "send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in distress."[7] While EMTALA gives some deference to state laws, the language of EMTALA is clear that it preempts any "State or local law requirement" to the extent that the requirement "directly conflicts with a requirement of this section."[8]

In June 2022, the Supreme Court decided *Dobbs v. Jackson Women's Health Organization*, overturning the constitutional protection to access an abortion before fetal viability, established almost fifty years prior in *Roe v. Wade* and

1. St. Anthony Hosp. v. U.S. Dep't of Health & Human Servs., 309 F.3d 680, 692 (10th Cir. 2002) (quoting H.R. Rep. No. 99-241, pt. 1, at 27 (1985)).

2. Provide "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists." *St. Anthony Hosp*., 309 F.3d at 692; 42 U.S.C. § 1395dd(a).

3. "[W]ithin the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition…" *St. Anthony Hosp*., 309 F.3d at 692; 42 U.S.C. § 1395dd(b)(1)(A).

4. *St. Anthony Hosp*., 309 F.3d at 693; 42 U.S.C. § 1395dd(g).

5. Arrington v. Wong, 237 F.3d 1066, 1069 (9th Cir. 2001).

6. 42 U.S.C. § 1395dd(a); *Arrington*, 237 F.3d at 1070.

7. Hardy v. N.Y.C. Health and Hospitals Corp., 164 F.3d 789, 792–93 (2d Cir. 1999); Reynolds v. MaineGeneral Health, 218 F.3d 78, 83 (1st Cir. 2000) (quoting 131 CONG. REC. S13904 (Oct. 23, 1985) (statement of Sen. Durenberger)).

8. 42 U.S.C. § 1395dd(f); *Hardy*, 164 F.3d at 793.

affirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[9] Following *Dobbs*, state laws restricting abortions, commonly called "trigger bans," that were enacted post-*Roe* in the event that the Supreme Court overturned *Roe* were "triggered," and pre-*Roe* abortion restrictions that were not repealed and remained on the books were attempted to be "revived."[10] Many of these state laws prohibited abortion in all cases or with very limited exceptions, such as to prevent the pregnant person's death.[11] Further, the limited exceptions to these prohibitions were often vaguely worded and did not provide guidance to hospitals and physicians, leaving physicians at risk for criminal penalties in some cases if an abortion deemed unnecessary after the fact was provided.[12]

The following month, in July 2022, in response to state laws restricting abortion, Centers for Medicare & Medicaid Services (CMS), part of the Department of Health & Human Services (HHS), issued guidance to hospitals and medical providers restating their obligation to continue to treat pregnant patients or patients experiencing pregnancy loss in compliance with EMTALA requirements.[13] On the same day the guidance was issued, the Secretary of HHS sent a letter to health care providers highlighting existing obligations under EMTALA, stating that EMTALA protects providers' clinical judgement and actions taken to provide stabilizing treatment for pregnant patients, regardless of state abortion restrictions.[14] The Secretary's letter and Agency guidance provide a non-exhaustive list of emergency medical conditions involving a pregnant person that physicians have a duty to stabilize, including "ectopic pregnancy, complications of pregnancy loss, or emergency hypertensive disorders, such as preeclampsia with severe features."[15] Notably, the guidance stated that if the necessary stabilizing treatment for the patient is an abortion, the physician must

9. *See generally* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); *see generally* Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); *see generally* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

10. *After* Roe *Fell: Abortion Laws by State,* CTR. FOR REPRODUCTIVE RIGHTS, https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited May 6, 2024).

11. Elizabeth Nash & Isabel Guarnieri, *13 States Have Abortion Trigger Bans—Here's What Happens When* Roe *is Overturned,* GUTTMACHER INST. (June 6, 2022), https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned.

12. *Id.*

13. CTR. FOR MEDICARE & MEDICAID SERV., QSO-22-22-Hospitals, REINFORCEMENT OF EMTALA OBLIGATIONS SPECIFIC TO PATIENTS WHO ARE PREGNANT OR ARE EXPERIENCING PREGNANCY LOSS at *1–2 (July 11, 2022, revised Aug. 25, 2022).

14. *HHS Secretary Letter to Health Care Providers About Emergency Medical Care*, DEP'T OF HEALTH AND HUM. SERV. 1 (July 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-healthcare-providers.pdf.

15. CTR. FOR MEDICARE & MEDICAID SERV., *supra* note 13, at *1, *4; DEP'T OF HEALTH AND HUM. SERV., *supra* note 14, at 1.

provide that treatment, and "[w]hen 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."[16]

Following the guidance, litigation in Idaho began over whether the state laws banning abortion could take effect. Idaho's trigger ban, section 18-622, banned abortion with extremely narrow exceptions and imposed felony penalties on health care professionals that performed abortions outside of those exceptions. The district court found that compliance with Idaho's statute criminalizing abortion was impossible because the statute stood as an obstacle to effectuating the full purpose and objective of EMTALA.[17] Accordingly, an injunction was granted.[18] The Supreme Court granted certiorari on the question and is poised to issue a decision this Term.[19]

Similar litigation in Texas began over whether HHS exceeded its authority in issuing the guidance.[20] Texas, H.B. 1280 section 2, the trigger law section that prohibits an abortion, took effect in August 2022. In *Texas v. Becerra*, the court granted Texas's motion for a preliminary injunction of the HHS guidance, holding that the guidance goes beyond the language of EMTALA, and HHS lacked the necessary statutory authority to issue the guidance.[21] The Fifth Circuit affirmed the district court's decision, concluding that EMTALA does not preempt state abortion laws because EMTALA "does not govern the practice of medicine" but leaves such matters to the states.[22]

This Note examines how state laws restricting abortions without exception for the pregnant person's health—or with exceptions narrower than the requirements in EMTALA—directly conflict with EMTALA's statutory requirements and stand as an obstacle to its purpose to provide patients with emergency care. Part II of this Note examines the history of EMTALA and its intent to protect vulnerable populations; EMTALA's statutory language and requirements, including its preemption clause preempting state laws that directly conflict with its requirements; and the effects of EMTALA on health care. Part III of this Note briefly acknowledges the inequitable impact state abortion

16. CTR. FOR MEDICARE & MEDICAID SERV., *supra* note 13, at *1; DEP'T OF HEALTH AND HUM. SERV., *supra* note 14, at 1-2.

17. United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022), *reconsideration denied*, No. 1:22-CV-00329-BLW, 2023 WL 3284977 (D. Idaho May 4, 2023).

18. *Id.* at 1117.

19. Idaho v. United States, 144 S. Ct. 541 (2024); Moyle v. United States, 144 S. Ct. 540 (2024). *See infra* Section III.A.

20. Texas v. Becerra, 623 F. Supp. 3d 696, 724–25 (N.D. Tex. 2022), *judgment entered*, No. 5:22-CV-185-H, 2023 WL 2467217 (N.D. Tex. Jan. 13, 2023), and *appeal dismissed*, No. 22-11037, 2023 WL 2366605 (5th Cir. Jan. 26, 2023).

21. *Id.* at 730.

22. Texas v. Becerra, 89 F. 4th 529, 543 (5th Cir. 2024).

restrictions have on individuals and communities of color and people with limited socioeconomic resources. Part IV examines state laws banning abortion in Idaho, Texas, Missouri, Arkansas, and Alabama, all of which are at risk for preemption to the extent that they conflict with EMTALA. Finally, this Note makes recommendations to state and federal lawmakers, and health care providers and hospitals based on the conclusion that a state abortion restriction that does not adopt the statutory requirements of EMTALA has a high likelihood of conflicting with EMTALA and thus being preempted to the extent of that conflict.

II. HISTORY OF EMTALA

A. Before EMTALA – Intent to Protect Vulnerable Groups

In February 1986, physicians from Cook County Hospital in Chicago released alarming results from a study showing disproportionate demographics and impacts on patients transferred to their public hospital.[23] The study showed eighty-nine percent of patients transferred to the public hospital were people of color, and that eighty-one percent of patients transferred were unemployed.[24] Notably, in eighty-seven percent of transfers the reason for transfer was a lack of adequate insurance, and twenty-four percent of patients were transferred despite their unstable medical condition.[25] Of all patients transferred, only six percent gave written, informed consent for the transfer.[26] Further, the study reported the poor outcomes that patients suffered as a result of those transfers: transferred patients were more than twice as likely to die at the receiving hospital as compared to patients receiving medical services at the hospital where they first arrived.[27] The study concluded that patients were transferred to a public hospital for overwhelmingly economic reasons, despite their unstable condition at the time of transfer.[28]

Again, in March 1987, physicians released a study summarizing the growing number of transfers of unstable patients to public hospitals in Dallas, Washington, D.C., and Chicago.[29] This practice of transferring patients from private hospitals to public hospitals for economic reasons was termed "patient dumping."[30] "Patient dumping" was defined as "the denial of or limitation in the

23. Robert L. Schiff et al., *Transfers to a Public Hospital. A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552, 552 (1986).

24. *Id.* at 553.

25. *Id*. at 553–54.

26. *Id.* at 554.

27. *Id.* at 555.

28. Schiff et al., *supra* note 23, at 556.

29. David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500, 1500 (1987).

30. *Id.*

provision of medical services to a patient for economic reasons and the referral of that patient elsewhere."[31] The study showed that in Dallas, the number of transferred patients increased from 70 per month in 1982 to more than 200 per month in 1983.[32] Likewise, in Washington, D.C., from 1981 to 1985, patient transfers increased from 169 annually to 930 annually.[33] In Chicago, the number of transfers increased from 1,295 annually to 5,652 annually between 1980 and 1984.[34] The growing concern over patient dumping and its impact was not isolated to large urban public hospitals but also extended to smaller cities and rural hospitals.[35] Patient dumping was a problem not only because of the significant economic pressure that it put on these public hospitals but also because of the barrier to health care that it created for people of color and people without the financial means to cover the cost of care.

Partly in response to this growing problem of patient dumping, Congress enacted the "Consolidated Omnibus Reconciliation Act" (COBRA), which was signed into law by President Reagan in 1986.[36] COBRA contained provisions affecting the old-age survivors and disability insurance, supplemental security income (SSI), as well as a provision intended to prohibit patient dumping, EMTALA.[37] Prior to EMTALA's enactment, the common law did not impose a duty on hospitals to undertake care for a patient who could not pay for service.[38] Hospitals were free to refuse treatment to anyone, regardless of their critical medical condition.[39] And while Title VI prohibited discrimination on the basis of race, color, or national origin by programs receiving federal funds, this prohibition primarily reduced blatant racial discrimination in health care, leaving hospitals free to transfer patients under the guise of economic considerations.

The barrier to health care for people of color and people with low socioeconomic status was clear. Despite prior guidance being issued to restrict hospitals' discrimination against these patients, no mechanism existed to enforce the restrictions.[40] For example, the Joint Commission on Accreditation of Hospitals issued a rule that "individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated,

31. *Id.*

32. *Id.*

33. *Id.*

34. Ansell & Schiff, *supra* note 29, at 1500.

35. *Id.*

36. Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What* it is and *What* it *Means* for *Physicians*, 14 BAYLOR UNIV. MED. CTR. PROC. 339, 339 (2001).

37. Mary Ross & Carol Hayes, *Consolidated Omnibus Budget Reconciliation Act of 1985*, 49 SOCIAL SECURITY BULLETIN 22, 22 (1986).

38. *Patient Dumping*, U.S. COMMISSION ON CIVIL RIGHTS i, 1 (Sept. 2014), https://www.usccr.gov/files/pubs/docs/2014PATDUMPOSD_9282014-1.pdf.

39. *Id*.

40. Zibulewsky, *supra* note 36, at 339.

regardless of race, creed, sex, nationality, or sources of payment for care."[41] Additionally, the American College of Emergency Physicians adopted a similar rule in its bylaws.[42] Federal laws such as the Hospital Survey and Construction Act of 1946 and various state laws attempted to address the issue of discrimination in emergency care.[43] However, hospitals continued to refuse care to patients or transfer patients with emergency medical conditions citing economic reasons, creating a disproportionate impact on these vulnerable groups.

B. Requirements of EMTALA

EMTALA was enacted to address the issue of patient dumping and ensure patients with emergency medical conditions are provided stabilizing care, regardless of their status. The core purpose of the statute is to "get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat."[44]

First, EMTALA applies to hospitals with an emergency department that participates in Medicare, also referred to as "participating hospitals."[45] "Emergency department" has been defined broadly to include patients in different departments of the hospital. In *Lopez-Soto v. Hawayek*, the court explained that the practice of patient dumping is a practice that is not limited to emergency departments, but that could exist in other departments of the hospital as well.[46] The court reasoned that if a hospital determined an admitted patient had developed an emergency medical condition, the hospital may be motivated by economic interests to transfer the patient elsewhere.[47] The court concluded this "strain of patient dumping is equally as pernicious as what occurs in emergency departments, and we are unprepared to say that Congress did not seek to curb it."[48]

Covered persons under EMTALA include *any* individual who presents to a participating hospital's emergency department requesting examination or treatment for a medical condition, regardless of the individual's employment status, adequacy of insurance, citizenship status, or ability to pay.[49] A request for treatment can be made by the individual or on their behalf.[50] When this

41. *Id*.
42. *Id*.
43. *Id*.
44. Bryan v. Rectors & Visitors of Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996).
45. 42 U.S.C. § 1395dd(e)(2).
46. Lopez-Soto v. Hawayek, 175 F.3d 170, 177 (1st Cir. 1999).
47. *Id*.
48. *Id*.
49. 42 U.S.C. § 1395dd(a).
50. *Id*.

request is made, the participating hospital is required under EMTALA to provide an "appropriate medical screening" within the hospital's capabilities to determine whether an "emergency medical condition" exists.[51] An "emergency medical condition" is defined in the statute as:

> (A) [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) With respect to a pregnant woman who is having contractions—
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
>
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[52]

Courts have interpreted the "appropriate medical screening" requirement to be a medical screening assessing for the presence of an emergency medical condition, that is uniform between patients in that hospital with a similar condition.[53] The screening given to any patient is required to be consistent with the standard screening procedures for that hospital, and comparable to other patients with a similar condition.[54] The medical screening is not based on an objective medical standard.[55] Courts have looked to existing hospital policies and procedures to determine whether the appropriate screening requirement was met.[56] Actual knowledge of an emergency medical condition is required to trigger the treat or transfer requirement.[57]

If an emergency medical condition is identified, the hospital is required to "stabilize" the medical condition within the capabilities of the facility, or to perform an appropriate transfer of the patient if one of the limited exceptions are

51. *Id*.

52. 42 U.S.C. § 1395dd(e)(1).

53. Zibulewsky, *supra* note 36, at 341.

54. Baber v. Hosp. Corp. of Am., 977 F.2d 872, 879 (4th Cir. 1992).

55. *Id.* at 879–80 (reasoning that EMTALA does not impose on hospitals a national standard of care in screening patients, but only requires a hospital to provide a screening examination that is "appropriate" and "within the capability of the hospital's emergency department," including "routinely available" ancillary services, as directed in 42 U.S.C.A. § 1395dd(a), noting that the standard will necessarily be individualized for each hospital, since hospital emergency departments have varying capabilities).

56. Zibulewsky, *supra* note 36, at 341.

57. *Baber*, 977 F.2d at 883.

met.[58] "Stabilize" is defined as providing treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual.[59] Unlike the medical screening requirement, stabilizing is based on an *objective* medical standard.

Transferring a patient with an unstable emergency medical condition is permitted only in limited situations when the express requirements are met. A transfer is appropriate if (1) the individual or their agent has requested the transfer in writing after being informed of the hospital's obligations, or (2) a physician signs a certificate that, based on the information available at the time of transfer, the benefits to the patient reasonably expected from the transfer outweigh the increased risks of the transfer.[60] Additionally, any appropriate transfer also requires that the receiving hospital have the available space and qualified personnel necessary for the treatment, and that the receiving hospital has agreed to accept the transfer and provide the appropriate treatment.[61] Further, the transfer must be conducted by qualified personnel with adequate transportation equipment.[62] A receiving hospital that has the equipment, space, and staff capacity to receive a transfer but refuses can also be held liable for "reverse patient dumping."[63]

CMS investigates allegations of failure to meet EMTALA requirements, and if CMS finds a violation, civil monetary penalties can be imposed on the hospital or the physician up to $50,000 for each violation.[64] Physicians are also at risk of exclusion from Medicare and Medicaid for gross and flagrant violations.[65] While EMTALA does not create a private right of action for individuals against physicians as in a medical malpractice claim, violations of EMTALA are actionable by the individual against the hospital.[66]

Notably, EMTALA requires that neither the examination or treatment of a patient be delayed in order to inquire about the individual's method of payment or insurance status.[67] EMTALA's requirement that "information gathering" not unduly delay treatment reflects the acknowledgment that health care, especially in an emergency setting, is different from other commercial goods and

58. 42 U.S.C. §§ 1395dd(b)(1)(A)–(B).
59. 42 U.S.C. § 1395dd(e)(3)(A).
60. 42 U.S.C. § 1395dd(c)(1).
61. 42 U.S.C. § 1395dd(c)(2).
62. 42 U.S.C. § 1395dd(c)(2)(D).
63. 42 U.S.C. § 1395dd(g).
64. 42 U.S.C. § 1395dd(d)(1).
65. *Id.*
66. 42 U.S.C. § 1395dd(d)(2)(A) ("Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.")
67. 42 U.S.C. §1395dd(h).

services.[68] For example, a delay caused by an uncertain contractor during the construction of a road may cause frustration and inconvenience for the commuters that frequent that path; by contrast, a delay caused by a hospital or a physician's uncertainty of conflicting laws during the administration of emergency treatment could result in significant impairment to the individual's health or even death.[69]

C. EMTALA Preemption of State Law

EMTALA provides that state and local laws in direct conflict with the statute are preempted: "[t]he 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."[70] Under the Supremacy Clause, the Constitution establishes federal law as the "supreme law of the land," and empowers Congress to preempt state law.[71] A federal statute can preempt state law by means of express preemption, field preemption,[72] or conflict preemption. When a federal law contains an express preemption clause, courts have to look to the "plain wording of the clause, which necessarily contains the best evidence of Congress' preemptive intent."[73]

State laws are preempted when they conflict with federal law, such as when (1) it is physically impossible to comply with both the state and federal regulation,[74] or (2) the state law stands as an "obstacle" to the accomplishment of the purposes of the federal law.[75] Congressional intent has been held to be the "ultimate touchstone" in determining whether a certain state action is preempted by federal law.[76]

68. Heather Skrabak, *(Con)textual Interpretation: Applying Civil Rights to Healthcare in Section 1557 of the Affordable Care Act*, 90 GEO. WASH. L. REV. 1291, 1311 (2022); Zibulewsky, *supra* note 36, at 340.

69. Skrabak, *supra* note 68, at 1311.

70. 42 U.S.C. § 1395dd(f).

71. U.S. CONST. art. VI, cl. 2; *see also* Crosby v. Nat'l Foreign Trade Council*,* 530 U.S. 363, 372 (2000).

72. Field preemption occurs when Congress, acting in its proper authority, precludes states from regulating conduct in a field that Congress has a framework of regulation "so pervasive . . . that Congress left no room for the States to supplement it" or where there is a "federal interest . . . so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject." Arizona v. United States, 567 U.S. 387, 399 (2012).

73. Chamber of Com. of U.S. v. Whiting, 563 U.S. 582, 594 (2011).

74. Florida Lime & Avocado Growers, Inc. v. Paul*,* 373 U.S. 132, 142–43 (1963).

75. *Arizona*, 567 U.S. at 399–400 (2012); *see also Crosby*, 530 U.S. at 373 (reasoning that the sufficiency of an obstacle is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purposes and intended effects).

76. Coons v. Lew, 762 F.3d 891, 902 (9th Cir. 2014), *as amended* (Sept. 2, 2014) (citing Gade v. Nat'l Solid Wastes Mgmt. Ass'n*,* 505 U.S. 88, 96 (1992)).

Courts have described EMTALA to have a "limited" preemption provision, as Congress did not intend EMTALA to be a substitute to state law on medical malpractice claims.[77] In drafting EMTALA, Congress deliberately left the establishment of medical malpractice liability to be managed by the states, intending the statute to have the specific effect of imposing a new duty on a hospital's emergency department to screen all patients uniformly and to stabilize any emergency condition discovered.[78] However, EMTALA does preempt any state law that directly conflicts with the requirements of the statute. For example, in the case *Matter of Baby K*, the Fourth Circuit held that the Virginia law exempting physicians from providing stabilizing treatment on the grounds of finding the treatment medically or ethically inappropriate was in direct conflict to EMTALA's statutory requirement to provide stabilizing treatment and therefore EMTALA preempted the state law.[79]

D. After EMTALA

EMTALA has undoubtedly expanded access to emergency health services, especially for individuals who are without insurance, underinsured, or have reduced access to care because of systemic inequities. Patient dumping between 2005 and 2014 continued to decrease, with rates as low as 1.7 violations per 1,000,000 emergency department visits.[80] Critics of EMTALA have cited the economic burden on hospitals in being compelled to pick up the tab for the increased utilization of emergency departments.[81] Emergency departments are responsible for the vast majority of uncompensated care in the United States, estimated at 42.67 billion dollars in 2020.[82] However, EMTALA has created a national health care safety net, giving all people access to stabilizing medical care—which is often the difference between life and death.

77. Hardy v. N.Y.C. Health and Hospitals Corp., 164 F.3d 789, 793 (2d Cir. 1999).

78. Brooks v. Maryland Gen. Hosp., Inc., 996 F.2d 708, 711 (4th Cir. 1993); Baker v. Adventist Health, Inc., 260 F.3d 987, 993 (9th Cir. 2001).

79. Matter of Baby K, 16 F.3d 590, 597, 598 (4th Cir. 1994).

80. Ryan M. McKenna et al., *Examining EMTALA in the era of the patient protection and Affordable Care Act*, AIMS PUB. HEALTH 367 (Oct. 8, 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6322999/pdf/publichealth-05-04-366.pdf.

81. Tristan Dollinger, *America 's Unraveling Safety Net: EMTALA's Effect on Emergency Departments, Problems and Solutions*, 98 MARQUETTE L. R. 1759, 1770 (2015).

82. *Uncompensated Care Fact Sheet*, AMERICAN HOSPITAL ASSOCIATION 3 (Feb. 2022), https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf.

III. OVERTURNING ROE IN DOBBS V JACKSON WOMEN'S HEALTH ORGANIZATION

A. Disparate Impact on Minorities

Many states implementing abortion restrictions are located in the South and Midwest of the United States, regions of the country where more Black, Latina, and Indigenous women live.[83] These abortion restrictions make accessing care limited to just people who can afford to travel out of their state, creating disproportionate barriers to care for women of color.[84] According to the CDC's Abortion Surveillance System, in 2019 more than half of abortions were among women of color, with thirty-eight percent accessed by Black women.[85] Many possible reasons exist for this increased utilization, including but not limited to, the limited access to comprehensive contraceptive options, the history of racist practices such as medical experimentation, and discrimination by individual providers.[86] Additionally, broad social determinants of health such as housing, racial and gender-based income disparities, and neighborhood safety also affect family planning and reproductive health decisions.[87]

IV. STATE LAWS AT RISK OF EMTALA PREEMPTION

A. Idaho

Idaho Code section 18-622 (Idaho's Ban), enacted in April 2022 as a trigger law,[88] criminalizes providing an abortion unless "[t]he physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was *necessary to prevent the death* of the pregnant woman."[89] The penalties for providing an abortion or attempting to provide an abortion outside of this limited "necessary-to-prevent-death" exception can include imprisonment and permanent loss of medical license.[90] While it was

83. Samantha Artiga et al., *What are the Implications of the Overturning of* Roe v. Wade *for Racial Disparities?*, KAISER FAMILY FOUNDATION (July 15, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/.

84. *Id*.

85. *Id*.

86. *Id*.

87. *Id*.

88. The trigger law was designed to take effect thirty days after judgment was entered in a Supreme Court decision allowing states to prohibit abortion. 2020 Idaho Sess. Laws 827.

89. IDAHO CODE § 18-622(2)(a)(i) (emphasis added).

90. IDAHO CODE § 18-622(1) ("Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion . . . shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall

later amended, the law initially required physicians to provide an affirmative defense that the abortion was necessary to prevent the death of the pregnant patient.[91]

After *Dobbs* triggered Idaho's Ban in June 2022, the United States brought suit against Idaho alleging that Idaho's Ban was preempted by EMTALA in the limited circumstances when the stabilizing treatment for a pregnant patient was an abortion, but when Idaho's ban did not allow such treatment because the pregnant person's life was not determined to be at risk.[92] The district court found EMTALA's stabilizing requirements are broader than Idaho's necessary-to-prevent-death exception and Idaho's Ban is preempted to the extent of that conflict.[93] The court entered a preliminary injunction August 2022 and denied reconsideration May 2023.[94] The petitioners appealed to the Nineth Circuit, where a panel initially granted a stay of the injunction pending appeal, concluding that Idaho's Ban does not conflict with nor stand as an obstacle to EMTALA's purpose because Idaho's Ban does not "interfere with the provision of emergency medical services to indigent patients."[95] The Nineth Circuit granted a rehearing en banc, vacated the panel decision, and reinstated the preliminary injunction.[96]

In January 2024, the Supreme Court stayed the preliminary injunction and granted certiorari on the question of whether EMTALA preempts Idaho's Ban in the narrow circumstances "where terminating a pregnancy is required to stabilize an emergency medical condition that would otherwise threaten serious harm to the pregnant patient's health but [Idaho] prohibits an emergency room

be permanently revoked upon a subsequent offense."). When the law was first enacted, no explicit exception was made for ectopic pregnancies. However, after the preliminary injunction, the Idaho Supreme Court construed "abortion," in connection with the definition of "pregnancy" as having a "developing fetus" in the body in § 18-604(11), to exclude ectopic and non-viable pregnancies. *See* Planned Parenthood Great Nw. v. Idaho, 522 P.3d 1132, 1203 (2023).

91. H.B. 374, 2023 Leg., 67th Sess. (Idaho 2023) (codified as amended at IDAHO CODE § 18-622). The district court found that Idaho's affirmative defense requirement "compounds the deterrent effect and increases the obstacle it poses to achieving the goals of EMTALA." United States v. Idaho, 623 F. Supp. 3d 1096, 1112 (D. Idaho 2022).

92. Complaint at 3, United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022) (No. 22 Civ. 329).

93. United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022), *reconsideration denied*, No. 1:22-CV-00329-BLW, 2023 WL 3284977 (D. Idaho May 4, 2023), and *cert. granted before judgment sub nom*. Moyle v. United States, 144 S. Ct. 540 (2024), and *cert. granted before judgment*, 144 S. Ct. 541 (2024).

94. *Id*. at 1117; United States v. Idaho, 1:22-CV-00329-BLW, 2023 WL 3284977, at *5 (May 4, 2023).

95. United States v. Idaho, 83 F.4th 1130, 1138–39 (9th Cir. 2023), *reh'g en banc granted*, *opinion vacated*, 82 F.4th 1296 (9th Cir. 2023).

96. United States v. Idaho, 82 F.4th 1296 (9th Cir. 2023).

physician from providing that care."[97] Professional organizations like the American College of Obstetricians and Gynecologists, American College of Emergency Physicians, and American Medical Association submitted a brief in support of the Government, identifying emergency medical conditions that put the patient's health in serious jeopardy—triggering EMTALA's objective stabilization requirement—but that Idaho's Ban would prohibit the option of an abortion to stabilize if a physician did not determine the treatment was necessary to prevent the patient's death; the emergency medical conditions include preterm prelabor rupture of the membranes (PPROM), miscarriage or early pregnancy loss (EPL), gestational hypertension and preeclampsia, excessive bleeding, or placental abruption.[98] The professional medical organizations emphasized that pregnancy termination has long been acknowledged in these emergency circumstances as a "necessary, standard, and evidence-based medical treatment" to stabilize patients when "continuing a pregnancy risks severe health consequences to the patient, like loss of uterus (and future fertility), seizures, stroke, vital organ damage and failure, and death."[99]

Despite this objective standard of care, physicians' ability to practice medicine and their freedom are at risk for providing such care in Idaho. Physicians are unable to comply with both EMTALA and Idaho's Ban because Idaho's Ban sets a far higher threshold than EMTALA establishes in both scope of injuries and timing.[100] First, while Idaho's Ban allows abortion only to prevent the pregnant patient's *death*, EMTALA requires stabilizing care when the absence of immediate medical attention would put the patient's *health* in serious jeopardy or cause serious bodily impairment or dysfunction.[101] Second, Idaho's Ban delays crucial care by imposing a non-medical certainty requirement that the procedure be "necessary" to prevent death, a requirement that medical professionals state is "not consistent with actual medical practice and will delay stabilizing treatment past the point when EMTALA and medical ethics require intervention."[102] Further, the possibility of prosecution and the

97. Idaho v. United States, 144 S. Ct. 541 (2024); Moyle v. United States, 144 S. Ct. 540 (2024). *See* Brief for Respondent at I, Idaho v. United States, 144 S. Ct. 541 (2024) (Nos. 23-726 and 23-727).

98. Brief of American College of Obstetricians and Gynecologists, American College of Emergency Physicians, American Medical Association as Amici Curiae in Support of Respondent at 8–10, Idaho v. United States 144 S. Ct. 541 (2024) (Nos. 230726 and 23-727); Brief for Respondent at 7, Idaho v. United States, 144 S. Ct. 541 (2024) (Nos. 23-726 and 23-727).

99. Brief of American College of Obstetricians and Gynecologists, American College of Emergency Physicians, American Medical Association as Amici Curiae in Support of Respondent at 10–11, 14–15, Idaho v. United States, 144 S. Ct. 541 (2024) (Nos. 230726 and 23-727).

100. *Id*. at 15–16.

101. *Id*.

102. *Id*.

associated risks inevitably lead physicians to delay or fail to provide the standard of care to pregnant patients as required by EMTALA.[103]

The Supreme Court heard oral argument for the case April 24, 2024.[104] Solicitor General Prelogar, arguing for the United States, highlighted the impossible position the Idaho Ban puts physicians and their pregnant patients in; pregnant patients are presenting to Idaho emergency rooms facing grave threats to their health, but when physicians are unable to say the patient is at risk of death, physicians are forced to decide between delaying care and airlifting the patient to a neighboring state to receive the necessary stabilizing treatment.[105] State laws that prevent vulnerable groups of patients from receiving stabilizing treatment and result in those patients either being denied care or being "dumped" on another state is consistent with what EMTALA was enacted to prevent. While EMTALA does not provide a list of emergency medical conditions or the appropriate stabilizing treatment, it does create a "baseline national standard of care to ensure that no matter where you live in this country, you can't be declined service and . . . the urgent needs of your medical condition addressed."[106] The Supreme Court's decision in this case will determine whether EMTALA's promise that all people can access emergency stabilizing care continues.

B. Texas

Texas designed its "trigger law," known as the "Human Life Protection Act" (HLPA), to take effect *if* the Supreme Court ever overruled *Roe*, wholly or in part, triggering HLPA's near total abortion ban thirty days after.[107] *Dobbs* triggered HLPA and its thirty-day timer, allowing the law to go into effect on August 25, 2022. HLPA is a near total ban on abortion, prohibiting abortion in all cases, unless the physician determines:

> (2) in the exercise of reasonable medical judgment, the pregnant female on whom the abortion is performed, induced, or attempted 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 or induced; and
>
> (3) the person performs, induces, or attempts the abortion in a manner that, in the exercise of reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in the reasonable medical judgment, that manner would create:

103. *Id*. at 18.

104. Transcript of Oral Argument, Idaho v. United States, 144 S. Ct. 541 (2024) (Nos. 230726 and 23-727).

105. *Id*. at 66.

106. *Id*. at 121.

107. H.B. 1280 §§ 2–3, codified as TEX. HEALTH & SAFETY CODE § 170A.002(b).

> (A)a greater risk of the pregnant female's death; or
>
> (B)a serious risk of substantial impairment of a major bodily function of the pregnant female.[108]

HLPA states it is not considered an abortion if the act is done with the intent to save the unborn child, remove a dead fetus caused by "spontaneous abortion," or remove an ectopic pregnancy.[109] Texas's pre-*Roe* abortion bans also remained on the books, which Texas attempted to revive following *Dobbs*, such as the 1925 statute criminalizing abortion with the narrow exception of saving the life of the pregnant person.[110]

The language in HLPA is narrower than the requirements in EMTALA, allowing for an abortion *only* in cases where the patient's life or major bodily function is at risk. Further, because of the steep penalties on providers for performing an abortion outside of the narrow restrictions, the determination of what condition meets the high threshold has been difficult to determine. In December 2023, the Texas Supreme Court overruled the trial court's order restraining HLPA's restriction of an abortion in the case of a Texas woman. The case was brought by Kate Cox, her husband, and her physician, Dr. Karsan, seeking to prevent the enforcement of HLPA under the medical necessity exception.[111] Kate Cox a thirty-one-year-old mother of two children, received the news that her fetus was diagnosed with trisomy-18.[112] This rare genetic condition involving an additional chromosome can cause fetal heart defects and other organ abnormalities[113] and results in a high risk of fetal death in utero or shortly after birth.[114] According to the pleading, Mrs. Cox's life and future fertility are at risk due to her prior caesarean sections increasing the risk of severe complications.[115]

The trial court ruled in favor of Mrs. Cox, finding that the prospective abortion fell within the medical exception to HLPA and issued an order restraining the Attorney General from enforcing the law against Dr. Karsan and others involved in the case.[116] However, the Texas Supreme Court overruled the

108. TEX. HEALTH & SAFETY CODE § 170A.002(b)(2)–(3) (emphasis added).

109. TEX. HEALTH & SAFETY CODE § 245.002(1).

110. TEX. REV. CIV. STAT. ARTS. 4512.1-.4, .6 (2010) (former TEX. PENAL CODE ARTS. 1191-94, 1196 (1925)).

111. Zoe Sottile et al., *Here's What We Know About a Texas Woman's Battle for an Abortion*, CNN (Dec. 11, 2023), https://www.cnn.com/2023/12/11/us/kate-cox-abortion-law-texas-case/index.html.

112. *Id.*

113. *Id.*

114. Geoff Mulvihill, *What We Know About the Legal Case of a Texas Woman Denied the Right to an Immediate Abortion*, AP NEWS (Dec. 12, 2023), https://apnews.com/article/abortion-texas-court-kate-cox-complications-3e24f473b0eab907993ddcad189e8115.

115. Sottile et al., *supra* note 111.

116. *Id.*

trial court's finding, and vacated the temporary restraining order.[117] The court stated that while the diagnosis to the fetus was devastating, "some difficulties in pregnancy, however, even serious ones, do not pose the heightened risks to the mother the exception encompasses."[118] The court went on to explain that a pregnant person who meets the medical-necessity exception "need not seek a court order to obtain an abortion,"[119] and that HLPA leaves discretion and responsibility to determine whether the exception is applicable to physicians, not judges.[120] The court concluded that the "reasonable medical judgment" requirement in HLPA is higher than a "good faith belief," and must be based on the objective medical standard.[121]

Texas's law, while not as narrow as Idaho's ban, is still in direct conflict with EMTALA's requirement to stabilize. The threshold in Texas for a pregnant patient to be offered the standard of care is death or "serious risk of substantial impairment to a major bodily function." By contrast, EMTALA's threshold is triggered sooner and with a broader scope of injuries including when a patient's health is in serious jeopardy, when a patient is at risk of serious impairment to bodily functions, or when a patient is at risk of serious dysfunction of any bodily organ or part. Further, the high standard Texas's law imposes on physicians for determining whether the serious-risk-of-substantial-impairment exception has been met will likely further prevent or delay care required by EMTALA.

C. Missouri

On the same day that the United States Supreme Court overturned *Roe*, Missouri's Attorney General issued an opinion letter giving effect to the Right to Life of the Unborn Child Act, which was enacted in 2019 as a trigger ban. The law prohibits abortion in all cases with a narrow exception for a "medical emergency."[122] A "medical emergency" is defined in the statute as a condition necessitating an abortion to prevent the death of the pregnant woman or "for which a delay will create the serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[123] This definition of medical emergency is significantly narrower than EMTALA's emergency medical condition definition.

This law has already caused a delay in treatment. A hospital in Joplin, Missouri is under investigation by CMS for violating EMTALA

117. In re State, 682 S.W.3d 890, 894–95 (Tex. 2023).
118. *Id.* at 892–93.
119. *Id.* at 893.
120. *Id.*
121. *Id.* at 894.
122. MO. REV. STAT. § 188.017(2) (2019).
123. MO. REV. STAT. § 188.015(7) (2019).

requirements.[124] The hospital allegedly informed a pregnant woman experiencing a medical emergency that the appropriate standard of care for her condition was an abortion, but that the hospital could not perform that abortion due to state restrictions.[125]

EMTALA requires the provision of stabilizing care to begin–without delay–when a medical condition is detected that could reasonably be expected to result in jeopardy to the person's health, bodily functions, or dysfunction to any body part or organ.[126] This requirement gives deference to the physician's judgment of the appropriate medical treatment but requires that the physician begin to administer stabilizing treatment as soon as any of those acute symptoms are detected. Notably, severe pain is recognized in the statute as an acute symptom of sufficient severity to be considered an emergency medical condition.[127]

In a situation where a pregnant person presents to a participating emergency department exhibiting any of those acute symptoms, such as being caused by preeclampsia, rupture of the amniotic sac, elevated blood pressure of vascular clot, or excessive bleeding, the physician would be required to begin immediately administering stabilizing treatment. In the situation when the standard of care for stabilization of that condition is an abortion, EMTALA would require a physician to perform that stabilizing treatment without delay. However, state statutes that would prevent the abortion as being outside the exception of causing an "irreversible physical impairment" would directly conflict with the requirements in the statutory language of EMTALA and would likely be preempted to the extent of that conflict.

Further, any physician who violates the Missouri statute can be charged with a class B felony and have their professional license revoked.[128] The statute establishes an affirmative defense that physicians charged with violating the statute have the burden of presenting evidence that they met the narrow exception.[129] The physician must present evidence that the abortion was performed because of a medical emergency, within the definition of the state statute.[130] This heavy burden involving exposure to criminal penalties and the requirement of presenting an affirmative defense is causing physicians, in fear

124. Rudi Keller, *Missouri Hospital the First Confirmed Federal Investigation of Denied Emergency Abortion*, MISSOURI INDEPENDENT (Nov. 2, 2022), https://missouriindependent.com/2022/11/02/missouri-hospital-the-first-confirmed-federal-investigation-of-denied-emergency-abortion/.

125. *Id*.

126. 42 U.S.C. § 1395dd(e)(1).

127. 42 U.S.C. § 1395dd(e)(1)(A).

128. MO. REV. STAT. § 188.017(2) (2019).

129. MO. REV. STAT. § 188.017(3) (2019).

130. *Id*. ("It shall be an affirmative defense for any person alleged to have violated the provisions of subsection 2 of this section that the person performed or induced an abortion because of a medical emergency. The defendant shall have the burden of persuasion that the defense is more probably true than not.")

of criminal prosecution, to delay or choose not to provide stabilizing treatment in some situations.[131] As the district court in *United States v. Idaho* found, this impact on treatment likely stands as an obstacle to the administration of EMTALA's requirements and therefore Missouri's law is at risk of being preempted to the extent of that conflict.[132]

D. Arkansas

In June 2022, following the United States Supreme Court's decision in *Dobbs*, it became illegal in Arkansas to perform an abortion with the narrow exception of saving the life of the pregnant person in a medical emergency.[133] Failure to comply with this law can result in a physician being charged with an unclassified felony, a fine of up to $100,000, and up to ten years in prison.[134]

The Arkansas Human Life Protection Act enacted in 2019 defines "abortion" as:

> [T]he act of using, prescribing, administering, procuring, or selling of any instrument, medicine, drug, or any other substance, device, or means with the purpose to terminate the pregnancy of a woman, with the knowledge that the termination by any of those means will with reasonable likelihood cause the death of the unborn child.[135]

It is not considered an abortion to (1) save the life or preserve the health of the unborn child; (2) remove a dead unborn child caused by spontaneous abortion; or (3) remove an ectopic pregnancy.[136] Importantly, a "medical emergency" is narrowly defined to mean a condition in which an abortion is necessary to *preserve the life* of a pregnant woman.[137]

The statute's limited exception for an abortion and narrow definition of medical emergency leaves the statute exposed to preemption by EMTALA in any situation when an abortion would be the stabilizing treatment to an emergency condition, as defined in EMTALA. Further, the chilling effect caused to physicians in delaying performing required stabilizing treatment very likely stands as an obstacle to the objectives of EMTALA.

131. Tessa Weinberg & Allison Kite, *Missouri Doctors Fear Vague Emergency Exception to Abortion Ban Puts Patients at Risk*, MISSOURI INDEPENDENT (July 2, 2022), https://missouriindependent.com/2022/07/02/missouri-doctors-fear-vague-emergency-exception-to-abortion-ban-puts-patients-at-risk/.

132. United States v. Idaho, 623 F. Supp. 3d 1096, 1112 (D. Idaho 2022), *reconsideration denied*, No. 1:22-CV-00329-BLW, 2023 WL 3284977 (D. Idaho May 4, 2023), and *cert. granted before judgment sub nom*. Moyle v. United States, 144 S. Ct. 540 (2024), and *cert. granted before judgment*, 144 S. Ct. 541 (2024).

133. ARK. CODE ANN. § 5-61-304(a) (2022).

134. ARK. CODE ANN. § 5-61-304(b) (2022).

135. ARK. CODE ANN. § 5-61-303(1)(A) (2022).

136. ARK. CODE ANN. § 5-61-303(1)(B) (2022).

137. ARK. CODE ANN. § 5-61-303(3) (2022).

E. Alabama

In 2019, the Alabama Human Life Protection Act was enacted as a near total ban on abortion, with no exception for rape or incest.[138] Quickly following the *Dobbs* decision in June 2022, the district court in *Robinson v. Marshall* granted a motion to dissolve the preliminary injunction on the Act, and Alabama's abortion ban went into effect.[139] Alabama's statute regulating abortion makes it unlawful for any person to intentionally perform or attempt to perform an abortion.[140] A narrow exception exists for when an attending physician licensed in Alabama determines that an abortion is necessary in order to prevent a "serious health risk" to the unborn child's mother and in the case of a medical emergency.[141] The State can criminally charge a physician who performs an abortion in violation of this law with a Class A felony or a Class C felony for an attempted performance.[142]

Alabama's statute defines some procedures as not being abortions, such as a procedure done with the intent to save the life or preserve the health of an unborn child, remove a dead unborn child, or deliver the unborn child prematurely in order to preserve the health of both the pregnant person and the unborn child.[143] The term "abortion" does not include a procedure or act to terminate the pregnancy of a woman with an ectopic pregnancy, nor does it include the procedure or act to terminate the pregnancy of a woman where the unborn child has a lethal anomaly.[144]

The Alabama statute defines a medical emergency as a condition that is likely to result in the death of the pregnant woman or is likely to result in substantial irreversible impairment of a major bodily function.[145] This definition is narrower than the requirements of EMTALA. EMTALA requires stabilizing treatment, without delay, when acute symptoms of an emergency condition are identified. Further, if treatment that would increase the risk of death to the fetus

138. Debbie Elliott & Laurel Wamsley, *Alabama Governor Signs Abortion Ban into Law,* NPR (May 14, 2019), https://www.npr.org/2019/05/14/723312937/alabama-lawmakers-passes-abortion-ban.

139. Robinson v. Marshall, No. 2:19CV365-MHT, 2022 WL 2314402 (M.D. Ala. June 24, 2022).

140. ALA. CODE § 26-23H-6 (1987).

141. ALA. CODE §§ 26-23H-1–26-23H-8.

142. ALA. CODE § 26-23H-6 (1987).

143. ALA. CODE § 26-21-2(3) (1987).

144. "For the purposes of Sections 26-21-1, 26-21-2, 26-21-3, 26-21-4, 26-21-6, 26-21-6.1, and 26-21-7, a "lethal anomaly" means the child would die at birth or be stillborn. For purposes of Sections 26-21-1, 26-21-2, 26-21-3, 26-21-4, 26-21-6, 26-21-6.1, and 26-21-7, the term "ectopic pregnancy" means any pregnancy resulting from a fertilized egg that was implanted or attached outside the uterus. The term "ectopic pregnancy" also includes a pregnancy resulting from a fertilized egg implanted inside the cornu of the uterus." ALA. CODE § 26-21-2(3) (1987).

145. ALA. CODE § 26-21-2(4) (1987).

is determined to be the best stabilizing treatment, the laws appear to require conflicting action by the physician.

While the exception for a substantial and irreversible impairment to the mother is slightly broader than the one allotted to physicians in Idaho, as discussed above, this is still significantly narrower than the requirements of EMTALA. As the district court in *United States v. Idaho* reasoned, EMTALA requires a physician to stabilize a patient to prevent any material deterioration of the medical condition, a requirement that often presents before the risk of irreversible impairment or when the life of the mother is at risk.[146] Refusing a patient stabilizing treatment as defined in EMTALA because the symptoms have not progressed to this rigorous standard required by the state directly conflicts with the statutory requirements of EMTALA.

V. RECOMMENDATIONS GOING FORWARD

A. Recommendations to State Lawmakers

State lawmakers should consider the statutory requirements of EMTALA and adopt specific statutory language and definitions such as "emergency medical condition" from EMTALA into the state laws to prevent preemption. Additionally, the state law should clarify that when an emergency condition is identified, and an abortion would be the standard of care in stabilizing that condition, the physician would not be subject to penalties in performing the necessary treatment. Further, states should remove the requirement that physicians present an affirmative defense, and instead create good faith protection for the administration of necessary stabilizing treatment when an emergency condition is determined to be present. Finally, when an abortion is the standard of care for stabilization, states should remove any requirement of a waiting period by the physician or the requirement to first employ alternative treatments.

B. Recommendations to Health Care Providers & Hospitals

To avoid civil penalties and the risk of Medicare termination, hospitals should ensure their policies for identifying and stabilizing an emergency medical condition in a pregnant person are consistent with the requirements of EMTALA. Additionally, hospitals should ensure staff are aware of and acting in accordance with these policies. Further, hospitals should have an on-call physician able to perform emergency obstetric care, such as an abortion, to comply with EMTALA requirements. Health care providers should keep records

146. United States v. Idaho, 623 F. Supp. 3d 1096, 1109 (D. Idaho 2022), *reconsideration denied*, No. 1:22-CV-00329-BLW, 2023 WL 3284977 (D. Idaho May 4, 2023), and *cert. granted before judgment sub nom*. Moyle v. United States, 144 S. Ct. 540 (2024), and *cert. granted before judgment*, 144 S. Ct. 541 (2024).

of emergency medical conditions that warrant an abortion to prevent material deterioration of an emergency medical condition.

C. Recommendations to the Federal Lawmakers

Congress's intent when enacting EMTALA was to ensure all people, regardless of their status or identity, have access to emergency medical care. Access to stabilizing obstetric care in an emergency situation, regardless of state restrictive laws, is vital to ensuring vulnerable populations have access to the most basic health care. Congress should enact a federal law protecting a pregnant person's access to an abortion to remove barriers from vulnerable populations.

VI. CONCLUSION

State abortion laws that do not adopt statutory language consistent with EMTALA's requirements for the stabilization of an emergency medical condition are at risk of being preempted. State abortion restrictions that have an exception only when the pregnant person's life is at risk directly conflict with EMTALA's requirement to stabilize an emergency medical condition and to prevent material deterioration of the condition. State abortion laws that require the physician to take additional waiting time or to employ alternative treatment methods before performing an abortion, when the abortion would be the standard care for stabilization, directly conflict with EMTALA's requirement to not delay stabilizing care. State abortion laws that impose criminal penalties on physicians for performing an emergency abortion or require the physician to present an affirmative defense stand as a significant obstacle to the accomplishment of EMTALA's requirements. If the state law directly conflicts with EMTALA's requirements, making it impossible to accomplish the requirements of EMTALA and comply with the state law, or if the state law stands as an obstacle to the accomplishment of EMTALA, then the state law ought to be preempted.

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