The Labor Divide: EMTALA's Preemptive Effect on State Abortion Restrictions

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Soon after the Supreme Court overturned Roe v. Wade *and the constitutional right to an abortion, the Biden administration began looking toward existing federal statutes as a means to preempt state abortion restrictions. One such statute, the Emergency Medical Treatment & Labor Act (EMTALA), sets mandatory standards of emergency care that hospitals throughout the country must provide. Since the Center for Medicare and Medicaid Services (CMS) released guidance (Guidance) interpreting EMTALA to preempt certain state-level restrictions on emergency abortions, there has been brewing disagreement among courts and agencies analyzing the issue.* Texas v. Becerra *exemplifies this disagreement. There, the court disagreed with the Guidance, finding that EMTALA did not preempt Texas's newly recently abortion law.*

Using the Guidance and Becerra *as a frame, this Comment presents a new interpretation of how EMTALA applies to the abortion context. Looking at both the original 1986 statute and a set of amendments in 1989, the Comment shows that EMTALA's preemptive effect differs depending on whether a pregnant woman has gone into labor or not. This "labor divide" is deeply ingrained in EMTALA's structure, text, and purpose, offering a foundation for a comprehensive framework determining what the statute requires across a variety of state-law restrictions and pregnancy-related emergency scenarios.*

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I. INTRODUCTION

A. Introductory context

In the wake of *Dobbs v. Jackson Women's Health Organization*[1] overturning *Roe v. Wade*[2] and the constitutional right to an abortion, the Biden administration has looked to a four-decades-old statute as a means to preempt state abortion restrictions.[3] The statute, the Emergency Medical Treatment & Labor Act (EMTALA),[4] requires that hospitals receiving Medicare funding stabilize patients with emergency medical conditions (EMCs).[5]

Even prior to *Dobbs*, courts had interpreted EMTALA to require physicians

1. 142 S. Ct. 2228 (2022).

2. 410 U.S. 113 (1973).

3. *See* David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 72-77 (2023). EMTALA is not the only place the Biden administration has looked toward to preempt state abortion restrictions. *See id.* at 54-70, 77-80 (discussing the Food and Drug Administration's Risk Evaluation and Mitigation System (REMS) and the Health Insurance Portability and Accountability Act (HIPAA) as potential additional vehicles for preemption). EMTALA, however, is the only federal action this Comment addresses.

4. 42 U.S.C. § 1395dd.

5. Moving forward, when this Comment refers to "hospitals," it means only those receiving Medicare funding. Nearly all the country's hospitals receive such funding, making this shorthand roughly accurate. *See Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid*, AM. HOSP. ASS'N, https://perma.cc/CYV6-N39F (stating that 94% of United States hospitals have at least 50% of inpatient days paid for by Medicare, meaning at least this many receive Medicare funding).

provide abortions when necessary to stabilize patients with EMCs.[6] But two weeks after *Dobbs*, the Center for Medicare and Medicaid Services (CMS) formalized its interpretation of EMTALA's preemptive effect in guidance (Guidance).[7] According to the Guidance, when a state law prohibits abortion and "draws [exceptions for the life and health of the mother] more narrowly than EMTALA's [EMC] definition—that state law is preempted."[8]

Disagreement has arisen in the lower courts over whether the Guidance correctly interpreted EMTALA. In one case, *Texas v. Becerra*, the district court upheld a preliminary injunction against enforcing the Guidance's interpretation, concluding instead that EMTALA requires hospitals to balance the unborn child's[9] health interests against the pregnant patient's[10] when determining her course of treatment.[11] By contrast, two other authorities have applied the Guidance's interpretation of EMTALA, finding it preempted state abortion laws.[12]

B. Core argument: EMTALA's labor divide

This Comment argues that, both the Guidance and *Becerra* notwithstanding, EMTALA's preemptive effect on state abortion restrictions differs depending on whether the pregnant patient has gone into labor. If she has not, EMTALA treats her like any other patient experiencing an EMC and requires hospitals provide stabilizing care—including an abortion—independent of concerns for her unborn child. The Guidance therefore correctly finds that EMTALA preempts state law requiring otherwise, and the *Becerra* court's contrary holding is incorrect.[13] But

6. *See infra* note 35.

7. Memorandum from the Ctr. for Medicare & Medicaid Servs. to State Survey Agency Directors, Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss (July 11, 2022), https://perma.cc/WF2C-EDAS.

8. *Id.* EMTALA has a preemption clause, stating that its "provisions . . . do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). The Second Circuit and several district courts have "uniformly construed" this clause to allow only impossibility and obstacle preemption. Texas v. Becerra, No. 22-CV-185, at *45 (N.D. Tex. Aug. 23, 2022) (order granting preliminary injunction). *Becerra* and *Idaho*, the two post-*Dobbs* EMTALA cases this Comment discusses, adopt the same approach. *Id.*; United States v. Idaho, No. 22-cv-00329, at *8 (D. Idaho Aug. 24, 2022) (order granting preliminary injunction).

9. This Comment uses the term "unborn child," as opposed to "fetus," to parallel referenced case law and statutory text, not to evoke any normative connotation.

10. This Comment uses the terms "pregnant patient," "pregnant woman," and "mother" interchangeably to mirror the language of the relevant statute and case law it discusses at a particular point.

11. TEX. HEALTH & SAFETY CODE § 170A.002(b)(2) (2021).

12. First, in *U.S. v. Idaho*, the court granted the United States's motion for preliminary injunction against enforcing Idaho's abortion law. *See infra* Part IV.A. Second, a Missouri CMS investigation applied the Guidance and found a hospital violated EMTALA when it would not provide a stabilizing abortion in order to comply with Missouri's abortion law. *See infra* Part IV.B.

13. Given healthcare regulation falls within states' historical police powers, courts have

once a patient has gone into labor, EMTALA treats her differently and requires the treating physician to balance the health interests of both the pregnant patient and the unborn child. In other words, the treating physician must affirmatively consider the risks to both the former and the latter's chance of survival in choosing a course of treatment.[14] *Becerra* therefore correctly finds EMTALA does not preempt state laws restricting abortions in order to achieve such balance in these scenarios.[15]

The remainder of this Comment proceeds as follows. Part II analyzes three key terms in both EMTALA's original 1986 text and its 1989 amendments to show that Congress embedded a labor divide into the statute.[16] Consequently, EMTALA requires only that physicians balance the unborn child's health interests when treating a pregnant woman in labor. Part III discusses and critiques *Becerra*, highlighting the court's error in concluding that EMTALA requires physicians to balance the unborn child's health interests at any stage of a patient's pregnancy. Part IV demonstrates EMTALA's preemptive effect on state abortion restrictions in three representative factual scenarios. Part V then concludes.

II. EMTALA'S KEY STATUTORY TERMS

A. Emergency medical condition

When originally adopted in 1986, EMTALA did not mention unborn children in its definition of EMCs. EMC was only defined as "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

traditionally applied a federalism canon to preemption analyses regarding the subject. That canon presumes no preemption and requires a clear statement from the statutory text to overcome that presumption. Texas v. Becerra, No. 22-CV-185, at *22 (quoting Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1996)). However, "in more recent years, the Supreme Court has declined to apply such a presumption in express-preemption cases." Thornton v. Tyson Foods, Inc., 28 F.4th 1016, 1023 (10th Cir. 2022) (citing several recent Supreme Court cases supporting this assertion). EMTALA's preemption clause only permits express preemption, thereby raising doubts regarding the federalism canon's applicability to the statute. *See supra* note 8. Not everyone, however, seems to agree the canon has been rolled back, making its application in express-preemption-only statutes like EMTALA unclear. *See* WILLIAM N. ESKRIDGE JR., PHILLIP P. FRICKEY & ELIZABETH GARRETT, LEGISLATION AND STATUTORY INTERPRETATION 301 (3d ed. 2022) (calling federalism canons "super strong" and, without mentioning an express-preemption caveat, calling applications concerning preemption their "most basic category").

14. *See infra* note 85.

15. *Becerra* itself does not consider that EMTALA's preemptive effect on state abortion restrictions might vary based on whether the patient is in labor or not. It, instead, focused on a pregnancy divide: concluding that EMTALA treats all pregnant women, regardless of their pregnancy state, differently than other patients. *See infra* Part III.

16. EMTALA defines "labor" as beginning at the mother's first contraction. 42 U.S.C. § 1395dd(e)(1)(B).

expected to result in (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part."[17] The definition represents Congress's chief focus in adopting the statute: ending hospitals' practice of so-called "patient dumping," where emergency rooms would refuse urgent care to patients who could not prove they had adequate insurance or cash on hand to pay for treatment.[18]

Wholly separate from EMCs, EMTALA also imposed obligations to stabilize a pregnant patient when she was in "active labor." Active labor was defined as the point in a pregnant woman's labor where "(A) delivery is imminent, (B) there is inadequate time to effect safe transfer to another hospital, or (C) a transfer may pose a threat of the health and safety of the patient or the unborn child."[19] This reference to the health and safety of an unborn child was the original text's only reference to unborn children. It and the legislative history show that Congress intended EMTALA to impose on hospitals a separate set of obligations with women in "active labor" than with EMCs, which had no corresponding obligation to stabilize unborn children of pregnant patients.[20]

In 1989, Congress adopted sweeping amendments to EMTALA.[21] These amendments did not significantly change "its original purpose and objectives," but only aimed to establish its scope and boundaries.[22] Along these lines of the amendments' purposes was to "clarif[y the] definitions of emergency medical condition[and] labor."[23] Among these clarifications, the amendments removed the "active" modifier from the term "labor," applying the statute to all patients in labor.[24] The amendments also structurally combined the terms "EMC" and

17. 42 U.S.C. § 1395dd(e)(1) (1986).

18. *See* 99 CONG. REC. 5520-21 (1985) (statement of Rep. Fortney H. Stark) (describing the so-called "wallet biopsy," where emergency rooms would examine the contents of a patient's wallet before agreeing to provide treatment and turning them away should they not be satisfied with the insurance card or cash they find on hand, and explaining how EMTALA would be enacted to proscribe the practice); 100 CONG. REC. 24-25 (1986) (statement of Rep. Fortney H. Stark) (referring to this language as part of EMTALA's "antidumping provisions" and reading into the congressional record several examples of patient dumping).

19. 42 U.S.C. § 1395dd(e)(2) (1986).

20. *See* 99 CONG. REC. 5521 (1985) ("If an emergency medical condition is found then the person must be treated to at least stabilize *the patient* or treat the active labor." (emphasis added)). Indeed, one Representative supporting EMTALA read from the House floor representations of patient dumping involving women in labor, leading to stillbirths, on two separate occasions. *Id*. at 5520-21; 100 CONG. REC. 25 (1986) (statement of Rep. Fortney H. Stark). No such statements are in the Congressional record for pre-labor pregnancy complications. *See* 99 CONG. REC. 5521 (1985); 100 CONG. REC. 25 (1986).

21. *Compare* 42 U.S.C. § 1395dd (1986), *with* 42 U.S.C. § 1395dd (1989). *See also infra* Appendix (detailing each 1989 amendment germane to this Comment's analysis).

22. Amy J. McKitrick, Note, *The Effect of State Medical Malpractice Caps on Damages Awarded Under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd)*, 42 CLEV. ST. L. REV. 171, 172-73 n.7-8 (1994).

23. H.R. REP. NO. 101-247, at 1035 (1989).

24. *See supra* note 16; *see also* Diana K. Falstrom, *Decisions Under the Emergency Medical Treatment and Labor Act: A Judicial Cure for Patient Dumping*, 19 N. KY. L. REV.

"labor," recategorizing "labor" from its prior status as a separate class of covered conditions to a subclass of EMCs. Thus since 1989, EMTALA's EMCs have been divided into two subclasses: non-labor EMCs, experienced by patients other than women in labor,[25] and labor EMCs, experienced only by women in labor.[26]

The amendments also expanded non-labor EMCs to include scenarios that place, "with respect to a pregnant woman, the health of the woman or her unborn child[] in serious jeopardy."[27] To this day, this is the only place EMTALA refers to pregnant women and their unborn children outside labor. The legislative history only mentions this addition in passing, stating it clarifies that the non-labor EMC definition "also applies to a condition that places in serious jeopardy the health of the woman or her unborn child."[28] It does not state or otherwise imply that Congress intended to mandate that doctors balance the pregnant woman's health interests against her unborn child's when treating her non-labor EMC.[29]

365, 375, 375 n.78 (1992) (discussing how Congress's intent from the change was to provide EMTALA's protections for "women in labor who have any complications with their pregnancies regardless of whether delivery is imminent"); Joan M. Stieber & Linda J. Spar, *EMTALA in the 90s – Enforcement Challenges*, 8 HEALTH MATRIX 57, 58 (1998) (stating that Congress removed the "active" qualifier because "no one could figure out the *legal* difference between 'active labor' and garden-variety 'labor'").

25. Patients in this subclass also include women in labor experiencing conditions unrelated and coincidental to their labor. *See infra* note 75.

26. 42 U.S.C. § 1395dd(e)(1)(A)-(B).

27. *Id*. § 1395dd(e)(1)(A).

28. H.R. REP. NO. 101-386, at 838 (1989). The Supplemental House Report also has a section titled "additional obligations," listing those that the amendments added to EMTALA. It does not mention a requirement to balance the risks to an unborn child against those of the patient when treating her pre-labor EMC. H.R. REP. NO. 101-247, at 1035 (1989). Though the section lists neonatal (post-birth) intensive care among the set of specialist facilities required to accept patients in need of their services, it does not mention facilities focusing on prenatal (pre-birth) care. *Id*.

29. This argument could hold more weight in state courts, given some employ purposivism more widely than do federal courts. *See generally* Abbe R. Gluck, *The States as Laboratories of Statutory Interpretation: Methodological Consensus and the New Modified Textualism*, 119 YALE L.J. 1750 (2010) (detailing states' wide usage of purposivism and legislative history); *see also* ESKRIDGE JR. et al., *supra* note 13, at 191-92 (defining purposivism as a methodology of statutory interpretation where the interpreter first determines the legislature's purpose in enacting a statute and then interprets that statute's words in the manner that best carries out that purpose). This purposivist bent can even influence state-court interpretation of federal statutes. *See id*. at 1963-65 (detailing examples where, despite claiming to apply federal-court principles of interpretation, state courts apply more purposivist methodologies that lead to different constructions from federal courts interpreting the same statute; also detailing examples where state courts explicitly apply their own state principles of statutory interpretation to federal statutes). Therefore, if a *Becerra*-like suit arose in state court, the difference in interpretive approach could change the outcome. This is not to say, however, that federal courts have fully abandoned purposivism when interpreting EMTALA. *See, e.g.*, *infra* note 57 and accompanying text.

B. Stabilization

If a patient has an EMC, EMTALA requires that hospitals "stabilize" her. For both labor and non-labor EMCs, EMTALA's original 1986 text defined "stabilize" to mean "provide [medical treatment of an EMC so] that no material deterioration of the condition is likely to result from the transfer of the individual from a facility."[30]

For labor EMCs, the 1989 amendments created a separate "stabilize" definition: "to deliver (including the placenta)." By contrast, they left the original definition virtually unchanged for non-labor EMCs.[31] This new two-tier definition of "stabilize" exemplified Congress's aim to treat labor EMCs differently from non-labor EMCs—even pregnancy-related non-labor EMCs that threaten the unborn child's health.[32]

Further, Congress did not add an explicit requirement to consider the health of the unborn child when stabilizing non-labor EMCs,[33] like it did for labor EMCs in other parts of EMTALA.[34] A physician treating a pregnant patient's non-labor EMC must therefore determine the stabilizing treatment irrespective of the unborn child's interests, even if that treatment is an abortion.[35]

30. 42 U.S.C. § 1395dd(e)(3) (1986).

31. *Id*. § 1395dd(e)(3)(A).

32. *See supra* note 28 and accompanying text.

33. Though there is also no such explicit requirement for labor EMCs' "stabilize" definition, the absence is only meaningful for non-labor EMCs. EMTALA's definition of "stabilize" for labor EMCs states a single possible stabilizing treatment: delivering the baby and placenta. 42 U.S.C. § 1395dd(e)(3)(A). Because EMTALA always requires the same treatment to stabilize labor EMCs, it eschews the case-by-case balancing and risk calculations physicians must engage in when determining the treatment to stabilize non-labor EMCs. *See id*.

34. *See infra* Part II.C. Reading such a balancing requirement into EMTALA's non-labor EMC "stabilize" definition would also contrast with how courts have interpreted other provisions in the Medicare Act, the broader statute within which EMTALA sits. Because the Medicare Act has a large number of express abortion carveouts, courts have consistently refused to find it treats abortions more restrictively than other procedures without explicit statutory language referencing the procedure. *See* Def.'s Brief in Support of their Motion to Dismiss and in Opposition to Plaintiff's Motion for a Temp. Restraining Order and Preliminary Injunction, Texas v. Becerra, No. 22-CV-185, at *27-28 (N.D. Tex. Aug. 15, 2022) [hereinafter *Becerra Opposition Brief*].

35. Pre-*Dobbs* EMTALA case law also supports this conclusion. In both *Becerra* and *Idaho*, several states jointly filed an amicus brief citing seven cases that found EMTALA requires abortions to stabilize patients with non-labor EMCs. Brief for California, et al. as Amici Curiae in Support of Defs. and in Opposition to Plaintiffs, Texas v. Becerra, No. 22-CV-185, at *6-7 (N.D. Tex. Aug. 16, 2022); Brief for California, et al. as Amici Curiae in Support of Plaintiffs' Motion for a Preliminary Injunction, United States v. Idaho, No. 22-CV-00329, at *6-7 (D. Idaho Aug. 16, 2022). The cases' analyses only discuss risks to the woman, not to her unborn child. *See, e.g.*, Ritten v. Lapeer Reg. Med. Ctr., 611 F. Supp. 2d 696, 714-16 (E.D. Mich. 2009); Morin v. Eastern Maine Med. Ctr., 779 F. Supp. 2d 166, 184-89 (D. Me. 2011). And outside the abortion context, courts have found that "EMTALA does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate." Matter of Baby K, 16 F.3d 590, 597 (4th Cir. 1994).

C. Transfer provisions

EMTALA's stabilization requirement is subject to multiple exceptions. One such exception allows a hospital to transfer a non-stabilized patent with an EMC to another facility if the treating physician determines the transfer's benefits would outweigh the risks to the patient and—since 1989 and only in the case of a labor EMC—to her unborn child.[36] One example could be if another facility has specialized treatment capabilities necessary to best meet the patient's needs. An acceptable transfer must also be "appropriate," meaning the hospital must conduct it in a manner that minimizes risk to the patient and—in the case of a labor EMC—to her unborn child.[37]

These transfer provisions continue the differential treatment of non-labor and labor EMCs identified above. Physicians are commanded to treat pregnant patients and their unborn children differently depending on whether the patients are experiencing non-labor or labor EMCs. Even though Congress's 1989 amendments recognized harms to unborn children as potential non-labor EMCs,[38] its changes to the transfer provisions do not compel physicians treating non-labor EMCs to consider whether pre-stabilization transfers would cause harm to the unborn child, by virtue of either the transfer itself or the "appropriate[ness]" of its means.[39]

Indeed, Congress explicitly caveated that the transfer provisions' unborn-child considerations applied only "in the case of labor."[40] Congress's differing treatment of the two EMC subclasses in this regard demonstrates its affirmative effort to cabin unborn-child considerations to labor EMCs, not to pre-labor pregnancy complications falling under non-labor EMCs.

III. CRITIQUE OF *BECERRA*'S PREGNANCY DIVIDE

Becerra is the only post-*Dobbs* judicial decision that has discussed in depth the statute's unborn-child language.[41] The case centers around the Texas Human Life Protection Act (HLPA), which—since going into effect on August 25, 2022—has banned abortions unless the mother "has a life-threatening physical

36. 42 U.S.C. § 1395dd(c)(1)(A)(ii).

37. *Id.* § 1395dd(c)(1)(B).

38. *See supra* text accompanying note 27.

39. *See* 42 U.S.C. § 1395dd(c)(2).

40. *Id.* Confirming this caveat, the 1989 amendments' Supplemental House Report states that "in the case of a pregnant woman in labor," physicians must account for the risks and benefits to the unborn child. H.R. REP. NO. 101-247, at 1034 (1989).

41. Though *Idaho* also analyzes EMTALA's preemptive effect on a state abortion restriction, that court granted a preliminary injunction against Idaho's abortion law because the law unduly inhibited doctors from stabilizing the mother irrespective of the risks to the unborn child. United States v. Idaho, No. 22-cv-00329, at *8-15 (D. Idaho Aug. 24, 2022). Unlike the *Becerra* court, the *Idaho* court therefore never needed to consider the extent that EMTALA required physicians to balance the unborn child's health interests against the mother's. *See id.*

condition" arising from a pregnancy that places her "at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed." If she has such a condition, HLPA permits a licensed physician to perform or induce an abortion in a manner that "provides the best opportunity for the unborn child to survive unless, in the [exercise of] reasonable medical judgment, that manner would create: (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."[42]

By the Guidance's interpretation, EMTALA preempts HLPA in cases where the Texas law prohibits physicians from providing abortions necessary to stabilize a pregnant patient.[43] Texas, however, filed suit to invalidate the Guidance as incorrectly interpreting EMTALA. The district court granted Texas's motion for a preliminary injunction against CMS enforcing the Guidance's interpretation in the district, finding a substantial likelihood that the Guidance's interpretation was invalid as applied to the Texas law. CMS has since responded by clarifying that the Guidance does not apply within Texas so long as the preliminary injunction is in effect.[44]

The court structures its opinion around a *Chevron* analysis,[45] finding that the Guidance's EMTALA interpretation should not receive deference.[46] As a threshold matter, it first finds that the Secretary of Health and Human Services, who

42. TEX. HEALTH & SAFETY CODE § 170A.002(b)(2).

43. *See supra* note 8.

44. *See supra* note 7.

45. *Chevron* deference is a judicial doctrine where a court defers to the relevant agency's interpretation of a congressional statute regarding its powers and mandates, as opposed to conducting its own statutory interpretation. Chevron, U.S.A., Inc. v. Nat'l Res. Def. Council, 467 U.S. 831, 843 (1984). To determine whether to provide an agency *Chevron* deference in its interpretation, courts first ask if Congress has delegated to the relevant actor power to make such an authoritative interpretation. *See infra* note 46. If so, it proceeds to a two-step test. Step one requires the court to determine whether Congress has spoken to the "precise question at issue" or left the interpretive question at issue ambiguous. *Chevron, U.S.A., Inc.*, 467 U.S. at 843. Step two asks whether the agency's interpretation is a "permissible construction of the statute." *Id*. A court will then adopt that agency's construction if it satisfies both steps. *Id*.

46. Neither Texas, nor the United States cited *Chevron* in their opening briefs. *See generally* Texas's Original Complaint, Texas v. Becerra, No. 22-CV-185 (N.D. Tex. Aug. 15, 2022) [hereinafter *Becerra Complaint*]; *Becerra Opposition Brief*. Texas instead argued the Guidance addresses a question of "deep economic and political significance," therefore triggering the major-questions doctrine's clear-statement rule. *See Becerra Complaint*, at ¶ 48 (citing West Virginia v. EPA, 142 S. Ct. 2587, 2609 (2022)). Though the United States argued to the contrary, it did not advocate for *Chevron* deference. *See Becerra Opposition Brief*, at *29. The court explained that, given Fifth Circuit precedent doing so as recently as 2019, it nonetheless applied *Chevron* out of an "abundance of caution." Texas v. Becerra, No. 22-CV-185, at *19 n.11. It, however, never addressed whether the United States' failure to invoke *Chevron* constituted implied waiver or forfeiture, despite a burgeoning circuit split on the issue. *Compare* Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives, 920 F.3d 1 (D.C. Cir. 2019), *with* Cargill v. Garland, No. 20-51016, at *27 (5th Cir. Jan. 6, 2023), *and* Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives, 140 S. Ct. 789, 790 (2020) (Gorsuch, J., statement respecting denial of certiorari). Though the *Becerra* court then stated

released the Guidance through CMS, had authority "to make rules carrying the force of law, and that the [Guidance's] interpretation claiming deference was promulgated in the exercise of that authority."[47] From there, the court moves onto *Chevron*'s two-step framework.[48] It finds the Guidance satisfies step one because EMTALA leaves ambiguous "whether physicians must perform abortions when they believe that it would resolve a pregnant woman's emergency medical condition, *irrespectiv*e of the unborn child's health and state law."[49] It then finds, however, that the Guidance fails step two. The court states that EMTALA imposes obligations "equally" with respect to both a pregnant patient and her unborn child, citing the unborn-child language Congress's 1989 amendments added to the non-labor EMC definition.[50] The court then points out that the Guidance does not address unborn children's health interest in the abortion context, despite the statute's "explicit concern" for them.[51] It therefore concludes the Guidance's construction ignores a crucial aspect of the statutory language and purpose,[52] making it an unreasonable interpretation that does not receive *Chevron* deference.[53]

that its findings would be on "even firmer ground" if it had applied the major-questions doctrine, it provided no detail on how it reached that conclusion. Texas v. Becerra, No. 22-CV-185, at *19 n.11. Nor did it reconcile discussing the major-questions doctrine or *Chevron* at all with the fact that it already purportedly applied another clear-statement rule: the federalism canon. *See id*. at *21. Therefore, *Chevron*'s questionable vitality notwithstanding, the court was perhaps apprehensive to rest its opinion on either clear-statement rule, given uncertainty surrounding their respective scopes. *See supra* note 13 (discussing uncertainty surrounding the federalism canon in express-preemption cases); Mila Sohoni, *The Major Questions Quartet*, 136 HARV. L. REV. 262, 266-67 (2022) (discussing uncertainty surrounding the scope of issues that trigger the major-questions doctrine). Fully grappling with these substantive canons, however, might have better fit with the Supreme Court's recent approach to agency-based questions of statutory interpretation as of late: applying what it views as the "best interpretation" without considering *Chevron* dereference one way or another. Indeed, this approach has featured in recent cases interpreting the Medicare Act—the broader statute within which EMTALA sits. *See* James Kunhardt & Anne Joseph O'Connell, *Judicial deference and the future of regulation*, BROOKINGS (Aug. 18, 2022), https://perma.cc/S58J-VRQ6 (citing Am. Health Ass'n. v. Becerra, 142 S. Ct. 1896 (2022); and Becerra v. Empire Health Found., 142 S. Ct. 2354 (2022)).

47. Texas v. Becerra, No. 22-CV-185, at *19 (quoting United States v. Mead Corp., 533 U.S. 218, 226-27 (2001)).

48. *See supra* note 45.

49. Texas v. Becerra, No. 22-CV-185, at *19.

50. *Id*. at *20-21.

51. *Id*. at *24.

52. Purposivism can often lead to broader statutory constructions than textualism. *See* WILLIAM N. ESKRIDGE, JR., PHILLIP P. FRICKEY & ELIZABETH GARRETT, LEGISLATION AND STATUTORY INTERPRETATION 193-94 (3d ed. 2022). It can thereby expand the set of interpretations that pass muster as "permissible" under step two. Contrarily, the *Becerra* court's analysis shows how a purposivist construction can sometimes lead to a less generous *Chevron* application.

53. Texas v. Becerra, No. 22-CV-185, at *23-25. CMS could get around this aspect of the ruling by issuing new guidance explicitly stating a physician's duty to stabilize the mother supersedes any competing duty to the unborn child. Making this addition would allow CMS

Ruling out *Chevron* deference, the court conducts its own statutory analysis.[54] It finds EMTALA does not preempt HLPA's abortion restrictions, structuring its analysis around a pregnancy divide, not a labor divide. The court reasons the 1989 EMTALA amendments "called particular attention" to Congress's intent that physicians "balance the health interest of the woman and her unborn child in emergency care," thereby treating pregnant patients (in labor or otherwise) differently from all others. Thus, HLPA mandating such balancing "carries out—rather than poses an obstacle to—the purposes of Congress," according to the court.[55] The opinion therefore concludes that, in requiring doctors provide the mother a stabilizing abortion in a manner that "provides the best opportunity for the unborn child to survive," HLPA is not preempted by EMTALA.[56]

The court's conclusion, however, stems from an incomplete analysis that does not consider EMTALA's non-labor EMC definition in context of the simultaneous amendments Congress made to other sections of the statute. Outside of a single footnote, the court does not discuss the numerous and explicit unborn-child obligations the amendments placed on hospitals when treating labor

to reach the same conclusion it currently does while addressing the *Becerra* court's step-two critique. Whatever this strategy's merits, however, the court is correct in noting that *Chevron* "may have fallen out of favor." Texas v. Becerra, No. 22-CV-185, at *19 n.11; *see also* Daniel M. Ortner, *The End of Deference: The States That Have Rejected Deference*, YALE J. REG.: NOTICE & COMMENT (Mar. 20, 2020), https://perma.cc/9DN5-YL5S (showing broadly the same trend at the state level). Therefore, CMS forcing the issue of *Chevron*'s continuing validity in this way is likely not its best strategy.

54. Though courts generally consider applying *Skidmore* deference after finding *Chevron* does not apply, *see* Christensen v. Harris County, 529 U.S. 576, 587-88 (2000), the court does not first consider doing so before reviewing the statute *de novo*, despite its purported "abundance of caution." *See* Texas v. Becerra, No. 22-CV-185, at *19 n.11. *Skidmore* deference entitles the agency's interpretation to "respect" to the extent that it is "persuasive." Christensen v. Harris County, 529 U.S. at 587-88. Though *Skidmore* has long been critiqued as an "empty truism" because a judge should regardless "take into account the well-considered views of expert observers," *see* United States v. Mead Corp. 533 U.S. 218, 250 (2001) (Scalia, J., dissenting), the Supreme Court still recognizes its "power to persuade." Georgia v. Public.Resource.Org, Inc., 140 S. Ct. 1498, 1510 (2020).

55. Texas v. Becerra, No. 22-CV-185, at *22.

56. *Id.* Independently, the court also found the Guidance was unduly adopted outside the Medicare Act's notice-and-comment requirements. *Id.* at *27-28. Though evaluating this part of *Becerra* is outside this Comment's scope, CMS has included its interpretation in an NPRM. Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47879 (Aug. 4, 2022). If properly adopted in the final rule, this should address the *Becerra* court's notice-and-comment concerns.

EMCs.[57] Because the court does not address this contrast,[58] it does not adequately refute the implications of EMTALA's labor divide.[59]

IV. APPLYING THE LABOR DIVIDE: EMTALA'S PREEMPTIVE EFFECT IN DIFFERENT SCENARIOS

A. Pre-labor emergency medical conditions

Pre-labor, the Guidance is correct that EMTALA preempts any state law restricting hospitals' ability to provide abortions when they are necessary stabilizing treatments. The *Becerra* court's analysis notwithstanding, the only reason EMTALA mentions unborn children in reference to pre-labor pregnancies is to "clarif[y]" that risk of harm to them without accompanying risk to the mother is sufficient to constitute a non-labor EMC.[60] This on its own, however, does not limit treating physicians' obligation when the mother herself faces a risk of harm. Physicians still must provide abortions when they are a necessary stabilizing treatment without balancing the health interests of the unborn child against those of the mother.

Idaho, the other post-*Dobbs* case analyzing EMTALA's preemptive effect on state abortion restrictions, provides illustrative facts. The case concerns an Idaho law that makes providing abortions a felony punishable by two to five years in prison.[61] The statute provides an affirmative defense a physician may raise at trial if she can show that: (1) the abortion was necessary to prevent the mother's death, and (2) she performed the abortion "in the manner that . . . provided the best opportunity for the unborn child to survive" unless doing so would have increased the mother's risk of death.[62]

The United States filed suit against Idaho seeking to enjoin the state's en-

57. Texas v. Becerra, No. 22-CV-185, at *20 n.12. In that footnote, the court cites EMTALA's stabilization definition as "appear[ing] to even prioritize the life of the unborn child in cases of pregnancy complications involving contractions." This supposedly stems from the provisions specifically citing delivery as the point at which the mother is "stabilized," while not mentioning abortion as an alternative endpoint. *Id*. The court, however, ignores the statute's broad use of the term "deliver." By immediately following "deliver" with the modifier "(including the placenta)," Congress made clear that the term refers to "deliver[ing]" all byproducts of labor, not exclusively a living child. An abortion would therefore also end in "deliver[y]" under EMTALA's use of the term. *See* 42 U.S.C. § 1395dd(e)(3)(A).

58. Similarly, the *Becerra* parties' opening briefs do not discuss the non-labor EMC language in context of the 1989 amendments' other unborn-child additions. *See Becerra Complaint*, at ¶ 27; *Becerra Opposition Brief*., at *28.

59. *See supra* Part II.

60. *See supra* text accompanying note 28.

61. IDAHO CODE § 18-622(2).

62. *Id*. § 18-622(3)(a)(ii)-(iii).

forcement of the Idaho law, putting forward the Guidance's interpretation to argue that EMTALA preempted it.[63] The district court found there was a substantial likelihood the United States would succeed on the merits, granting a preliminary injunction against enforcing the Idaho law.[64]

Among other reasons, the *Idaho* court found EMTALA preempts the Idaho law under an impossibility-preemption theory because the affirmative defense only applies when the mother faces a risk of death.[65] EMTALA's stabilization requirement, by contrast, applies to mothers with any EMCs—a broader set than only potentially fatal conditions.[66] In cases where the mother has an EMC that is not potentially fatal, it is therefore impossible for a physician to comply with both EMTALA and the Idaho abortion law.[67]

This Comment's interpretation of EMTALA illustrates an additional reason the statute preempts Idaho's abortion restriction. The Idaho law's affirmative defense requires the treating physician perform a stabilizing abortion in the method that provides the unborn child "the best opportunity to survive," unless that method would result in "a greater risk of death" to the mother.[68] The law says nothing about abortion methods that result in a greater risk of non-fatal harm to the mother. In pre-labor scenarios, EMTALA requires physicians to use the method of treatment that minimizes risk of harm to the mother irrespective of the risk to the unborn child.[69] It therefore also preempts the Idaho law because the latter restricts treating physicians' ability to provide the abortion method that would minimize risk of non-fatal harm to the mother.

B. Emergency medical conditions during labor

1. When the physician cannot save the unborn child

When a pregnant patient is in labor, EMTALA requires physicians consider risks to both her and the unborn child. In cases where the physician cannot save the unborn child, however, it has no risk to balance. Therefore, only the risks and benefits to the mother are relevant to the physician's course of action under EMTALA. That means the statute preempts state abortion restrictions in these scenarios to the same extent as for pre-labor pregnant patients.

A recent Missouri CMS investigation illustrates this type of case. The investigation centered around a pregnant woman whose water broke early, just under

63. United States v. Idaho, No. 22-cv-00329, at *10 (D. Idaho Aug. 24, 2022).
64. *Id*. at *14-15.
65. *Id*. at *8.
66. *See* 42 U.S.C. § 1395dd(e)(1); *supra* Part II.A.
67. *Idaho*, No. 22-cv-00329, at *8.
68. IDAHO CODE § 18-622(3)(a)(ii)-(iii).
69. *See supra* text accompanying note 35.

eighteen weeks into her pregnancy.[70] After deeming the pregnancy was not viable, treating physicians determined an abortion was the necessary stabilizing treatment because she would otherwise face a serious risk of harm from infection.[71] The hospital's legal team, however, informed the woman the hospital would not conduct the procedure due to legal risk under Missouri's new abortion law. Though the law provided an affirmative defense for physicians who could show by a preponderance of the evidence they provided the abortion because of a "medical emergency,"[72] the legal team determined the woman here did not face such an "emergency." So they turned her away.[73] She was only able to receive the treatment she needed and terminate her pregnancy after crossing the state border for treatment in Illinois, outside the reach of Missouri law.[74]

In this case, the Guidance was correct that EMTALA mandated that the treating hospital provide an abortion. The examining physician determined an abortion was the necessary stabilizing treatment and the unborn child had no chance of survival. The analysis is therefore much the same as *Idaho*'s: The hospital needed to provide the abortion irrespective of the unborn child's health interests.

2. When the physician can save the unborn child

When a woman in labor has an EMC and the treating physician determines she can also save the unborn child, EMTALA does not preempt state abortion restrictions like Texas's HLPA. States may therefore limit the stabilizing treatment hospitals provide the mother in order to decrease risk to the unborn child in these scenarios.[75] Treating them differently from non-labor EMCs aligns with

70. Harris Meyer, *Hospital Investigated for Allegedly Denying an Emergency Abortion After Patient's Water Broke*, KAISERHEALTHNEWS (Nov. 1, 2022), https://perma.cc/W9K8-8N6A. It is not clear whether the patient had experienced contractions after her water broke, placing her in EMTALA-defined labor. *Id*. Regardless, contractions often do follow similar complications, and this Comment proceeds under the assumption she had them, too. *See Preterm Prelabour Rupture of Membranes (pPROM): Care Instructions*, MYHEALTH.ALBERTA.CA (last updated Feb. 9, 2022), https://perma.cc/64W4-QZZK. Additionally, this scenario shows how EMTALA's labor provisions can often apply outside the latest stages of pregnancy. *See id*.

71. Harris Meyer, *Hospital Investigated for Allegedly Denying an Emergency Abortion After Patient's Water Broke*, KAISERHEALTHNEWS (Nov. 1, 2022), https://perma.cc/W9K8-8N6A.

72. MO. REV. STAT. § 188.017.

73. Harris Meyer, *Hospital Investigated for Allegedly Denying an Emergency Abortion After Patient's Water Broke*, KAISERHEALTHNEWS (Nov. 1, 2022), https://perma.cc/W9K8-8N6A.

74. *Id*.

75. This is true only for complications related to the labor itself, not unrelated EMCs a mother happens to suffer when in labor. It may, however, prove difficult to draw the line between a non-labor EMC spuriously occurring during labor and a labor-related complication. Given the harsh criminal penalties state abortion bans place on offenders, physicians will almost certainly err on the side of caution when a woman is in labor and take into account the health interests of the unborn child when treating her EMC, regardless of what caused it.

EMTALA's labor divide.[76]

A variation in the above-discussed Missouri CMS investigation's facts provides an illustrative example.[77] If the treating physician had determined the unborn child could survive, EMTALA would not preempt a state law requiring the physician consider its health interests along with the mother's.[78] Though EMTALA would still preempt the Missouri law for the same reasons the *Idaho* court discussed in its opinion (at least to the extent its term "medical emergency" is narrower than an EMC),[79] EMTALA would not preempt a law like Texas's HLPA, which requires the physician act to maximize the unborn child's chance of survival to the extent doing so does not put the mother at risk of death or substantial impairment of a major bodily function.[80]

V. CONCLUSION

At its inception, EMTALA divided the patients it protected into two groups: those in labor and everyone else experiencing medical emergencies.[81] When amended in 1989, the statute retained this labor divide. It embedded it within the separation between non-labor and labor EMCs,[82] added it to the stabilization requirement,[83] and added it to the transfer provisions.[84] Consequently, EMTALA places different requirements on physicians treating women in labor than it does on individuals with non-labor EMCs, including those who are pregnant.

A crucial way that EMTALA treats labor differently than it does all other EMCs is by requiring physicians independently consider the risks to the unborn child when treating a pregnant patient. The *Becerra* court's analysis notwithstanding, the reference to unborn children Congress added to the definition of non-labor EMCs does not remove this distinction. The Guidance is therefore correct that EMTALA preempts any state law restricting hospitals from providing abortions to stabilize pre-labor EMCs. It is incorrect, however, regarding EMTALA's preemptive effect once the patient has gone into labor. In these scenarios, EMTALA does not preempt state laws like Texas's HLPA from requiring

76. *See supra* Part II.

77. These scenarios are not uncommon. For pregnancies only a few weeks further along than that of the woman in the Missouri investigation, it is not impossible for the unborn child to survive. *Preterm Prelabour Rupture of Membranes (pPROM): Care Instructions*, MYHEALTH.ALBERTA.CA (last updated Feb. 9, 2022), https://perma.cc/64W4-QZZK.

78. Again, this example assumes the patient experienced contractions. *See supra* note 70.

79. *See supra* Part IV.A.

80. *See* TEX. HEALTH & SAFETY CODE § 170A.002.

81. This is evident even in EMTALA's name, Emergency Medical Treatment & Labor Act, which separates "Labor" from other "Emergency Medical Treatment." *See* 42 U.S.C. § 1395dd.

82. *See supra* Part II.A.

83. *See supra* Part II.B.

84. *See supra* Part II.C.

that physicians reach a certain balance when considering the risks to the mother and the unborn child if it might survive.[85]

Though for now the Biden administration seems fully committed to the Guidance's interpretation,[86] EMTALA's labor divide should guide future agencies' interpretations of the statute, judicial analyses of its preemptive effect, and state-law exemptions from abortion restrictions.[87] Though structuring an unvarying divide around the mother's first contraction might not always seem descriptively satisfying,[88] doing so hews closely to EMTALA's text, structure, and Congress's purpose in enacting both the original statute and its 1989 amendments. It also removes substantial uncertainty regarding how this four-decades-old law will shape emergency care in a post-*Dobbs* world.

VI. APPENDIX

This Appendix shows Congress's 1989 amendments to EMTALA. The crossed-out language is what Congress removed; the underlined language is what Congress added. For clarity and focus, the Appendix omits portions of EMTALA and amendments this Comment does not discuss (denoting areas where text was removed with ellipses):

85. That is not to say state laws can require physicians disregard risks of harm to the mother altogether when determining the course of treatment. EMTALA requires that physicians consider these risks as well. *See supra* text accompanying notes 65-67 (discussing the *Idaho* court's finding that EMTALA preempted Idaho's abortion law for inadequately considering risks to the mother).

86. *See* U.S. DEP'T OF HEALTH & HUM. RES., MARKING THE 50TH ANNIVERSARY OF ROE: BIDEN-HARRIS ADMINISTRATION EFFORTS TO PROTECT REPRODUCTIVE HEALTH CARE 3 (2023) (affirming the Biden administration's commitment to the Guidance's interpretation); Celine Castronuovo, *Abortion's New Battleground: Biden Clashes With States Explained*, BLOOMBERG L. (Jan. 23, 2023), https://perma.cc/QG2R-Y5PD (discussing HHS communicating the same commitment to reporters on a conference call).

87. Multiple chances might soon arise to put forward such an interpretation. Firstly, parties in both *Becerra* and *Idaho* have filed appeals with the Fifth and Ninth Circuits respectively. *See* Hannah Albarazi, *Abortion Litigation to watch as* Dobbs *Turns 1*, LAW360 (June 22, 2023), https://perma.cc/J2U4-BV4V (discussing how the Fifth and Ninth Circuits reaching different conclusions on EMTALA's preemptive effect "would likely prompt the Supreme Court to take up and issue a decision on the matter."). Secondly, the National Women's Law Center has filed a complaint on behalf of the Missouri woman discussed above with the U.S. Department of Health and Human Service's Office of Civil Rights. *Federal complaint filed on behalf of Joplin woman in emergency medical care case*, JOPLIN GLOBE (Jan. 30, 2023), https://perma.cc/ZVW5-46NE. This is on top of the above-mentioned CMS investigation. *See supra* note 70 and accompanying text. Given this Comment finds EMTALA preempted the Missouri restriction, *see supra* Part IV.B.1, it could underpin a successful legal analysis to vindicate the Missouri woman's rights much the same as can the Guidance. *See id*.

88. Indeed, whatever one's views on abortion, it might seem normatively irrelevant to the above-discussed Missouri investigation whether or not contractions accompanied the patient's water breaking. *See supra* note 70.

42 U.S.C. § 1395dd: Examination and treatment for emergency medical conditions and women in labor

. . .

(b) Necessary stabilizing treatment for emergency medical conditions and ~~active~~ labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition ~~or is in active labor~~, the hospital must provide either-

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition ~~or to provide for treatment of the labor~~, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

. . .

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of ~~subsection (e)(4)(B)) or is in active labor~~ subsection (e)(3)(B)), the hospital may not transfer the individual unless-

(A)

. . .

(ii) a physician (within the meaning of section 1395x(r)(1) of this title), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that based upon ~~the reasonable risks and benefits to the patient, and~~ the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the ~~individual's medical condition~~ individual and, in the case of labor, to the unborn child from effecting the transfer, or

. . .

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

. . .

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer-

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

. . .

. . .

(e) Definitions

In this section:

(1) The term "emergency medical condition" means—~~means 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—~~

~~(A) placing the patient's health in serious jeopardy,~~

~~(B) serious impairment to bodily functions, or~~

~~(C) serious dysfunction of any bodily organ or part.~~

(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

~~(2) The term "active labor" means labor at a time at which—~~

~~(A) delivery is imminent~~

~~(B) there is inadequate time to effect safe transfer to another hospital prior to delivery~~

~~(C) a transfer may pose a threat to the health and safety of the patient or the unborn child.~~

. . .

~~(4)~~(3)

(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

. . .

(f) Preemption

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.

. . .