Nos. 23-726, 23-727

IN THE

Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writs of Certiorari Before Judgment to the United States Court of Appeals for the Ninth Circuit

BRIEF OF 258 MEMBERS OF CONGRESS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

ELIZABETH B. WYDRA
BRIANNE J. GOROD*
MIRIAM BECKER-COHEN
CONSTITUTIONAL ACCOUNTABILITY CENTER
1200 18th Street NW, Suite 501
Washington, D.C. 20036
(202) 296-6889
brianne@theusconstitution.org

Counsel for Amici Curiae

March 28, 2024

* Counsel of Record

A complete list of the 49 U.S. Senators and the 209 Members of the U.S. House of Representatives participating as *amici curiae* is provided as an appendix to the brief. Among them are:

Majority Leader Charles E. Schumer
Sen. Patty Murray
Sen. Ron Wyden
Sen. Richard J. Durbin
Leader Hakeem Jeffries
Whip Katherine Clark
Rep. Frank Pallone, Jr.
Rep. Richard E. Neal
Rep. Jerrold Nadler
Rep. Diana DeGette
Rep. Barbara Lee

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INTEREST OF *AMICI CURIAE*[1]

Amici are Members of Congress currently serving in the Senate and House of Representatives. They have a strong interest in protecting the supremacy of federal laws Congress enacts, including laws that are authorized by the Constitution's Spending Clause and designed to protect the health and safety of their constituents. As *amici* well know, the Emergency Medical Treatment and Labor Act (EMTALA) is such a law, and the plain text of EMTALA means that abortion must be offered when it constitutes the necessary stabilizing treatment for a pregnant patient experiencing a medical emergency.

A full list of *amici* appears in the Appendix.

INTRODUCTION AND SUMMARY OF ARGUMENT

Amidst "a growing concern about the provision of adequate emergency room medical services to individuals who seek care," H.R. Rep. No. 99-241, pt. 3 at 5 (1985), the 99th Congress passed EMTALA to ensure that every person who visits a Medicare-funded hospital with an "emergency medical condition" is offered stabilizing treatment, 42 U.S.C. § 1395dd(b)(1)(A). Congress chose broad language for that mandate, requiring hospitals that participate in the Medicare program to provide "such treatment as may be required to stabilize the medical condition." *Id.* That text—untouched by Congress for the past three decades—

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[1] Under Rule 37.6 of the Rules of this Court, *amici* state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici* or their counsel made a monetary contribution to its preparation or submission.

makes clear that in situations in which a doctor determines that abortion constitutes the "[n]ecessary stabilizing treatment" for a pregnant patient, *id.* § 1395dd(b), federal law requires the hospital to offer it.

Yet Idaho has made providing that care a felony, in direct contravention of EMTALA's mandate that it be offered. Pursuant to our Constitution's Supremacy Clause, *see* U.S. Const. art. VI, cl. 2, Idaho's law must give way. Under this controlling rule of decision, "states have no power . . . to retard, impede, burden, or in any manner control the operations of the constitutional laws enacted by [C]ongress to carry into effect the powers vested in the national government." *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 317 (1819).

In this case, respecting the supremacy of federal law is about more than just protecting our system of government; it is about protecting people's lives. If this Court allows Idaho's near-total abortion ban to supersede federal law, pregnant patients in Idaho will continue to be denied appropriate medical treatment, placing them at heightened risk for medical complications and severe adverse health outcomes. And health care providers, forced to let Idaho's abortion law take precedence over their medical judgment about their patients' best interests, will continue their exile from Idaho, creating maternity-care "deserts" all over the state. *See* Julianne McShane, *Pregnant with No OB-GYNs Around: In Idaho, Maternity Care Became a Casualty of Its Abortion Ban*, NBC News (Sept. 30, 2023), https://tinyurl.com/ys4frtx2 (noting that thirteen of Idaho's forty-four counties are already considered maternity-care deserts—places that lack hospitals providing obstetrics care, birth centers, OB-GYNs, or certified midwives); *Dozens of Idaho Obstetricians*

Have Stopped Practicing There Since Abortions Were Banned, Study Says, AP (Feb. 21, 2024), https://tinyurl.com/3wu4ta6n (more than fifty obstetricians have stopped practicing in Idaho since the state's law went into effect); Angela Palermo, *Idaho Needs Doctors. But Many Don't Want to Come Here. What that Means for Patients*, Idaho Statesman (Mar. 11, 2024), https://tinyurl.com/2x4txmjx (Idaho has lost fifty-five percent of its maternal-fetal medicine specialists—doctors who address high-risk pregnancies—and three rural hospitals have shut down maternity services altogether).

These are not hypothetical scenarios. Because Idaho's abortion ban contains no clear exceptions for the "emergency medical conditions" covered by EMTALA, physicians are forced to wait until their patients are on the verge of death before providing abortion care. The result in other states with similar laws has been "significant maternal morbidity." Anjali Nambiar *et al.*, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstet. & Gynecol. 648, 648-49 (2022). For instance, after Texas enacted a total abortion ban, one study showed that 57% of patients in that state experienced "serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances . . . in states without such legislation." *Id.* at 649; *see also* Kelcie Moseley-Morris, *Her Fetus Had 1% Chance of Survival. Idaho's Ban Forced Her to Travel for an Abortion*, Idaho Capital Sun (May 10, 2023), https://tinyurl.com/vahze48 (describing an Idaho woman named Jennifer Adkins who had to travel to Oregon to receive abortion care for a non-viable pregnancy that put her at risk for mirror syndrome and

preeclampsia, a life-threatening state of high blood pressure that can cause seizures and organ damage); Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN (Nov. 16, 2022), https://tinyurl.com/ua4nnz43 (describing a Texas woman named Amanda Eid who went into septic shock after her water broke at just eighteen weeks because doctors delayed abortion care for her until she was "sick enough that [her] life was at risk"). Federal law does not allow Idaho to endanger the lives of its residents in this way.

1. The plain text of EMTALA makes clear that Idaho's ban is preempted to the extent it prevents physicians from providing abortion when necessary to stabilize a patient experiencing an "emergency medical condition." The statute provides that "[i]f any individual (whether or not eligible for [Medicare benefits]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide . . . within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition," 42 U.S.C. § 1395dd(b)(1)(A), or for "transfer of the individual to another medical facility in accordance with [certain requirements]," *id.* § 1395dd(b)(1)(B). There are no exemptions in the text of the statute for abortion, or any other specific medical procedures that a doctor might deem the necessary "stabilizing treatment." Thus, under EMTALA, abortion care must be provided when, in a doctor's professional judgment, termination of a pregnancy is necessary to prevent placing a patient's health in "serious jeopardy," or to avoid "serious impairment to bodily functions," or "serious dysfunction of any bodily organ or part," *id.* § 1395dd(e)(1)(A).

Contrary to Petitioners' assertions, it is irrelevant that EMTALA does not explicitly list abortion as a stabilizing treatment; indeed, the statute does not list *any* specific stabilizing treatments. And, as *amici* well know, this approach makes sense given the way Congress drafts statutes: Congress does not write laws by articulating every possible scenario those laws might cover. This is especially true when a law—like EMTALA—relies on technical medical expertise for its proper implementation, as Congress is a body of lawmakers, not physicians. In the case of EMTALA, Congress chose to use broad language in the statute to allow physicians to use their medical judgment without political interference.

If EMTALA's own text were not enough to make clear that the law requires doctors to offer abortion care in emergency situations, more recent legislation (crafted by many *amici*) leaves no doubt. A section of the Patient Protection and Affordable Care Act (ACA) addressing "special rules" regarding abortion states that "[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as 'EMTALA')." 42 U.S.C. § 18023(d). Thus, the one time Congress enacted statutory text expressly addressing both abortion and EMTALA together, it did so to make clear that EMTALA *authorizes* rather than *exempts* abortion, and to ensure that no provision of the ACA would be construed to alter that fact. This is additional probative textual evidence of the scope of EMTALA's coverage.

Petitioners advance several other arguments for writing an atextual abortion exception into EMTALA's "stabilizing treatment" requirement, all of which

should be rejected. Remarkably, they assert that EMTALA does not require *any* stabilizing treatment at all because it was passed primarily for the purpose of ending the practice of private hospitals "dumping" indigent and uninsured patients in public hospitals' emergency rooms. But Petitioners construe EMTALA's purpose too narrowly: Congress was concerned about discrimination against indigent and uninsured patients, *and* it was also concerned that hospitals were failing to meet their basic emergency treatment obligations to the general public. EMTALA's broad text reflects this dual purpose.

Petitioners also assert that EMTALA's requirement that emergency rooms provide only those stabilizing treatments "within the staff and facilities available at [a particular] hospital," 42 U.S.C. § 1395dd(b)(1)(A), means that federally funded hospitals in Idaho are no longer obliged to provide abortion under EMTALA because abortion is no longer "available" under state law in the emergency circumstances covered by EMTALA. Again, this argument rests on a fundamental misinterpretation of EMTALA's text. The phrase "within the staff and facilities available" merely limits hospitals' obligation to provide stabilizing treatment to those treatments within their *physical* capacities. A hospital without a cardiothoracic surgeon does not have to perform heart surgery. A hospital without an MRI machine does not have to perform an MRI. Nowhere is there any indication—in the text or history of EMTALA—that Congress meant to exempt doctors from providing a stabilizing treatment they are fully capable of providing and have performed hundreds or even thousands of times because a state has newly imposed criminal punishment on such treatment.

Finally, this Court should reject Petitioners' argument that EMTALA's reference to the "unborn child" implicitly carves out abortion from EMTALA's stabilizing-treatment requirement. *See* 42 U.S.C. § 1395dd(e)(1)(a) (defining an "emergency medical condition" to include conditions that could "plac[e] the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy"). Rather than restrict hospitals' obligations with respect to pregnant patients, the reference to a fetus expands the obligation: it requires a hospital to provide treatment to a pregnant patient who presents with a condition that *does not* presently pose a serious threat to the patient's own health, but *does* pose a serious threat to the fetus's health. EMTALA's amendment history supports this commonsense understanding: in 1989, Congress moved the language specifically addressing fetuses from a provision related to an individual in "active labor" to the general definition of "emergency medical condition," thus closing a loophole that had limited hospitals' stabilizing-treatment requirement when a pregnant woman herself was not experiencing an emergency medical condition, but her fetus was.

2. Once this Court recognizes that EMTALA requires abortion when necessary to stabilize a patient presenting with an emergency medical condition, it is clear that Idaho's near-total abortion ban is preempted to the extent that it prevents pregnant patients from receiving that care. Petitioners and their *amici* offer remarkably little argument about the Idaho law itself to refute that point. Instead, they assert that EMTALA is not entitled to preemptive effect because it was enacted pursuant to Congress's spending power.

This Court should reject that argument, as it has many times before. Under the Supremacy Clause, *all*

"the constitutional laws enacted by congress," *McCulloch*, 17 U.S. (4 Wheat.) at 317, constitute "the supreme Law of the Land," U.S. Const. art. VI, cl. 2. As this Court has repeatedly held, the principle of federal supremacy applies to laws, like EMTALA, passed pursuant to Congress's spending authority no less than it does to laws effectuating other enumerated powers. *See, e.g.*, *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 636 (2013); *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 279-80 (2006); *Blum v. Bacon*, 457 U.S. 132, 138 (1982). That effectuates the plain text of the Supremacy Clause, which contains no carve-out for Spending Clause statutes, and is perfectly logical: once federal money is accepted, conditions attached to its receipt become just as binding on the recipient as any other federal law.

Of course, private parties have the choice whether or not to accept federal funding, and the strings attached to it, in the first place. But it is *Congress* that our Constitution empowers to offer that choice. States do not have the power to take that choice away by making it impossible for funding recipients to comply with both the terms of federal spending law and state law. If that were the case, states could nullify federal laws without restraint—precisely what Idaho has attempted to do in this case.

In sum, EMTALA plainly requires hospitals that participate in the Medicare program to provide abortion care when, in a doctor's professional judgment, it constitutes the "[n]ecessary stabilizing treatment" for a patient's "emergency medical condition." 42 U.S.C. § 1395dd(b)(1). Thus, to the extent that Idaho's near-total abortion ban prevents hospitals from fulfilling that mandate, the state law must give way under the rule of federal supremacy.

ARGUMENT

I. EMTALA Mandates that Hospitals Provide Abortion Care When It Constitutes the Necessary Stabilizing Treatment for an Individual's Emergency Medical Condition.

A. EMTALA's Text Requires the Provision of Whatever Stabilizing Treatment Is "Necessary to Assure, Within Reasonable Medical Probability," Against "Material Deterioration of the [Patient's] Condition."

Every hospital with an emergency department that participates in Medicare is required to certify compliance with EMTALA as a condition of accepting federal funding. *See* 42 U.S.C. § 1395dd(e)(2); *id.* § 1395cc(a)(1)(I)(i). Under EMTALA, "any individual (whether or not eligible for [Medicare benefits])" who comes to a participating hospital's emergency department seeking "examination or treatment for a medical condition" must be given "an appropriate medical screening examination" so that the hospital can "determine whether or not an emergency medical condition . . . exists." *Id.* § 1395dd(a). If "the hospital determines that the individual has an emergency medical condition," it must either offer "such further medical examination and such treatment as may be required to stabilize the medical condition" "within the staff and facilities available at the hospital," or it must provide "for transfer of the individual to another medical facility in accordance with" certain requirements. *Id.* § 1395dd(b)(1).

As relevant here, EMTALA defines the term "emergency medical condition" 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 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." *Id.* § 1395dd(e)(1)(A). And the statute specifies that "to stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." *Id.* § 1395dd(e)(3)(A).

The text of these statutory provisions makes several things clear. First, EMTALA covers "any individual," regardless of that individual's indigency or eligibility for Medicare coverage. *Id.* § 1395dd(a), (b)(1). Second, the hospital "*must* provide" either for "such treatment as may be required to stabilize" the individual, or "for transfer," in accordance with certain conditions, when an individual presents with an "emergency medical condition." *Id.* § 1395dd(b)(1) (emphasis added). Third, the stabilizing treatment provided must include all medical treatment within the hospital's capacity "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 [a] transfer." *Id.* § 1395dd(e)(3)(A). Fourth, the statute focuses on the potential *outcomes* for the patient in defining "emergency medical condition," and it is neutral as to the *cause* of the "emergency medical condition"—meaning a condition stemming from pregnancy itself (as opposed to, say, a car accident) may be the source of an "emergency medical condition." *Id.* § 1395dd(e)(1)(A). And finally, the hospital is required to provide "stabilizing treatment" even if the patient is

not necessarily at risk of death. Thus, in accordance with EMTALA's plain text, when a physician determines that termination of a pregnancy is the "[n]ecessary stabilizing treatment" to avoid placing a patient's health "in serious jeopardy," or causing "serious impairment to bodily functions," or "serious dysfunction of any bodily organ or part," EMTALA requires hospitals to offer and provide that treatment, subject to the patient's informed consent. *Id.* § 1395dd(b), (e)(1)(A).

B. EMTALA Does Not Carve Out Abortion from Its Requirements.

EMTALA's text does not exempt physicians from providing any form of medical treatment, whether related to abortion or anything else. Rather, the statute's broad text requiring physicians to provide whatever care constitutes the "[n]ecessary stabilizing treatment" reflects Congress's decision to leave the choice of the appropriate treatment to a physician's determination "within reasonable medical probability." *Id.* § 1395dd(e)(3)(A). This Court should respect that judgment.

Other legislation helps explain why. For example, in the *same legislation* that ultimately became EMTALA, *see* Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. 3128, 99th Cong., § 124, Congress considered creating a grant program "to prevent teenage pregnancies and to assist pregnant individuals and teenage parents in achieving self-sufficiency," *id.* § 302. For that program, Congress specified that "[n]one of the activities conducted or services provided . . . may include the performance of abortions, or include the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term." *Id.* § 302(b)(2)(B). Thus, Congress knew how to exempt abortion from a funding program at the time that it

drafted EMTALA; it simply chose not to do so for cases where abortion constitutes the "[n]ecessary stabilizing treatment" for an "emergency medical condition," 42 U.S.C. § 1395dd(b)(1).

Moreover, as *amici* remember well, Congress enacted certain restrictions on coverage for abortion when it passed the ACA in 2010. For example, after much debate, a provision proposed by Senator Ben Nelson was added that allowed states the option to prohibit abortion coverage in insurance markets or exchanges. *See* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 L. Lib. J. 131, 157 (2013); 42 U.S.C. § 18023(a)(1) ("A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition."). Notably, this restriction was explicit in the text of the ACA.

And that very same section of the ACA dedicated to special rules on abortion is the one place in the United States Code where the terms "abortion" and "EMTALA" appear together. After listing various explicit abortion *restrictions*, including the Nelson Amendment, the section makes clear that "[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as 'EMTALA')." 42 U.S.C. § 18023(d). In other words, when Congress enacted the ACA, it expressly contemplated that EMTALA might require medical providers at participating hospitals to offer abortion as a "[n]ecessary stabilizing treatment for emergency medical conditions," *id.* § 1395dd(b), and it made clear that they were authorized to provide that care. This point bears emphasis: the one time Congress enacted statutory text expressly

addressing both abortion and EMTALA, it did so to make clear that EMTALA *authorizes* rather than *exempts* abortion, and to ensure that no provision of the ACA would be construed to alter that fact.

In sum, EMTALA's clear and broad text dictates that when a physician determines that a patient is suffering from an "emergency medical condition," a participating hospital is required to provide "for such further medical examination and such treatment as may be required to stabilize the medical condition." *Id.* § 1395dd(b)(1). When abortion constitutes that "[n]ecessary stabilizing treatment," *id.* § 1395dd(b), EMTALA requires that it be offered.

C. Petitioners' Purposive Arguments Are Wrong Twice Over.

Perhaps recognizing the breadth of EMTALA's text, Petitioners essentially argue that this Court should focus instead on the statute's purpose, which, they say, was to prevent "patient-dumping." *See, e.g.*, Moyle Br. 43; Idaho Br. 29 (EMTALA "merely ensures that indigent patients are not denied treatments that are authorized under state law for paying patients"). Petitioners' argument that the Court should in this case elevate statutory purpose over text is wrong, and Petitioners are wrong about the purpose of EMTALA in any event.

To start, even if Petitioners' narrow view of EMTALA's purpose were correct, it could not override the statute's text, which requires hospitals to provide the minimum level of treatment necessary to "stabilize" an individual experiencing an "emergency medical condition," 42 U.S.C. 1395dd(b)(1). That requirement extends to "*any* individual (whether or not eligible for benefits [through Medicare])," 42 U.S.C. § 1395dd(a),

(b) (emphasis added)—a point Petitioners do not dispute—and it always has, *see* Pub. L. 99-272, § 9121(b), 100 Stat. 82, 164 (1986) (original enactment). Thus, though one of EMTALA's purposes certainly was to eliminate hospitals' practice of denying care to patients without the means to pay for emergency care, Congress clearly chose broader language. It did not write a statute stating that "hospitals must treat uninsured or indigent patients the same as paying patients"; instead, it mandated the provision of basic "stabilizing treatment" for *all* patients.

In any event, contrary to Petitioners' assertions, EMTALA's history makes clear that while preventing patient-dumping was one of the statute's goals, it was hardly the only one. EMTALA was also passed to ensure that hospitals fulfilled their basic emergency treatment obligations to the general public, as its text reflects. For instance, the Conference Committee described the House bill it adopted as requiring "all participating hospitals [to] . . . provide further examination and treatment within their competence to stabilize the medical condition." H.R. Rep. No. 99-453, at 473-74 (1985) (Conf. Rep.); *see also* H.R. Rep. 99-241, pt. 1 at 27 (1985) ("all participating hospitals must, when a patient is found to have an emergency condition . . . provide further examination and treatment within their competence to stabilize the medical condition"). Floor statements from key sponsors of the legislation were to like effect. Senator Ted Kennedy, one of EMTALA's co-sponsors, explained that "[t]his amendment will ensure that hospitals live up to their fundamental responsibilities to the public." 131 Cong. Rec. 28,569 (1985). Certainly, that means that hospitals must do more than simply *fail all patients equally*. Why would Congress fund hospitals that did not

pledge to fulfill their most basic "responsibilities to the public"? *Id.*

D. EMTALA Does Not Permit Physicians to Decline to Provide Stabilizing Treatments that States Have Criminalized.

Petitioners also argue that the statute does not require hospitals to provide certain stabilizing treatments if "state law prohibits . . . such treatments," Idaho Br. 25, pointing to EMTALA's limitation of its stabilizing-treatment requirement to that which is "within the staff and facilities available at the hospital," 42 U.S.C. § 1395dd(b)(1)(A). In other words, according to Petitioners, if a treatment such as abortion is *legally* unavailable, then EMTALA does not mandate that it be provided.

That is an improper reading of the statutory text. EMTALA's limitation to treatment "within the staff and facilities available at the hospital" simply makes clear that hospitals need only provide services that they have the staff and equipment to provide.

First, and most importantly, EMTALA uses the term "available" to refer directly to a hospital's "staff and facilities." *Id.* Staff and facilities are (and were at the time EMTALA was enacted) *physical* assets of a hospital—its people and its space and machinery. *See, e.g.*, *Webster's New Collegiate Dictionary* 406 (8th ed. 1981) (defining "facility" as "something (as a hospital) that is built, installed, or established to serve a particular purpose"); *Facility*, Oxford English Dictionary, https://www.oed.com/dictionary/facility_n?tab=meaning_and_use#4935835 (last visited Feb. 21, 2024) ("the *physical* means or equipment required for doing something, or the service provided by this" (emphasis added)); *see also Webster's New Collegiate Dictionary*

1122 (8th ed. 1981) (defining "staff" as "the officers chiefly responsible for the internal operations of an institution or business"); *Staff*, Oxford English Dictionary, https://www.oed.com/dictionary/staff_n1tab=meaning_and_use#21129921 (last visited Feb. 21, 2024) ("[a] group of people employed to carry out the work of an organization").

Petitioners' own authorities illustrate this point. For instance, Idaho invokes *Baker v. Adventist Health, Inc.*, 260 F.3d 987 (9th Cir. 2001), a case which held that a hospital was not required to offer psychiatric treatment when "it had no psychiatrists or any other mental health professionals on staff," Idaho Br. 29 (citing *Baker*, 260 F.3d at 991). This makes perfect sense: EMTALA does not require a hospital to provide a patient with intensive care if the hospital does not have an intensive care unit; it does not require a hospital to provide orthopedic treatment if an orthopedist is not on staff. The issue in this case is not that Idaho hospitals do not have the necessary equipment for abortions or doctors capable of providing abortion as a stabilizing treatment; the issue is that Idaho has *outlawed* that form of stabilizing treatment with the goal of making it unavailable.

Further undermining Petitioners' construction of the statute is the fact that EMTALA authorizes transfer to another hospital if appropriate stabilizing treatments are not *physically* available at the initial hospital where an individual presented with an emergency medical condition. *See* 42 U.S.C. § 1395dd(c)(1)(A)(ii) (authorizing transfer when a physician has signed a certification that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual"). Indeed, under such circumstances, the receiving hospital is *required* by

EMTALA not to turn away the transferee. *See id.* § 1395dd(g) ("A participating hospital that has specialized capabilities or facilities (such as *burn units, shock-trauma units, neonatal intensive care units* . . .) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." (emphasis added)). Congress thus was focused on the specific medical resources that are physically available at each hospital it funds. It understood that not every hospital would be able to, say, stabilize a severe burn patient, and it thus created a structure under which such a patient could be transferred to an appropriate facility.

Again, EMTALA's history confirms what its text makes clear. For instance, EMTALA's Conference Committee adopted the House bill language, which the Conference Report described as requiring that hospitals "provide further examination and treatment *within their competence* to stabilize the [emergency] medical condition." H.R. Rep. No. 99-453, at 473-74 (1985) (Conf. Rep.) (emphasis added); *see also* H.R. Rep. 99-241, pt. 1 at 27 (1985) (identical language). The concept of a hospital's "competence" accords with the idea that a hospital must provide only those treatments that it has the staff and equipment to perform. This limitation was designed to protect hospitals that lack specialized equipment and facilities from civil liability for failing to provide services beyond their competence (indeed, requiring a hospital to provide services that it lacks the competence to perform could compromise the wellbeing of patients). The limitation was *not* designed to authorize hospitals to decline to provide a stabilizing treatment that they plainly have the competence to perform—a treatment they have performed hundreds or even thousands of times—

simply because a state has newly imposed a criminal punishment on the provision of such treatment.

Senator David Durenberger, the EMTALA floor manager, made this clear when he said that "[t]he purpose of this amendment is to send a clear signal to the hospital community, public and private alike, that all Americans . . . should know that a hospital will provide *what services it can* when they are truly in physical distress." 131 Cong. Rec. 28,568 (1985) (emphasis added). Senator Robert Dole, a co-sponsor of EMTALA, similarly stated on the record that "[u]nder the provision of this amendment, a hospital is charged only with the responsibility of providing an adequate first response to a medical crisis. That means the patient must be evaluated and, at a minimum, provided with *whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution* and the well-being of the patient." *Id.* at 28,569 (emphasis added).

It is thus clear that EMTALA's limitation to "the staff and facilities available at the hospital," 42 U.S.C. § 1395dd(b)(1)(A), simply refers to the treatments that a hospital is physically capable of providing. EMTALA requires a hospital to provide any treatment within its capabilities "as may be required to stabilize [a patient's] medical condition," 42 U.S.C. § 1395dd(b)(1), full stop. There is no getting around that straightforward text and the statutory history behind it.

E. EMTALA's Reference to Fetuses Does Not Alter Its Requirement that Hospitals Provide Abortion When Necessary to Stabilize an Individual's "Emergency Medical Condition."

Finally, Petitioners assert that because EMTALA "explicitly promises . . . protection for an 'unborn

child,'" the statute cannot possibly require abortion as a "stabilizing treatment" when pregnancy places a person's health in serious jeopardy. Idaho Br. 4; *see* Moyle Br. 26. That argument rests on a fundamental misreading of EMTALA's text.

EMTALA defines an "emergency medical condition" 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 expected to result in . . . placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). At the same time, EMTALA's screening, stabilization, and transfer obligations all expressly run to the "individual." *See id.* § 1395dd(a) (hospital must "provide for an appropriate medical screening examination" when "any *individual* (whether or not eligible for [Medicare benefits]) comes to the emergency department and a request is made on the *individual's* behalf" (emphasis added)); *id.* § 1395dd(b)(1) (requiring "[n]ecessary stabilizing treatment" or transfer, under certain circumstances, when the "*individual* has an emergency medical condition" (emphasis added)). Thus, the reference to an "unborn child" in the definition of "emergency medical condition" merely expands the scope of EMTALA's screening and stabilization requirements to cover situations in which the "individual" faces no risk of serious health impairment (or at least, her condition has not progressed to that stage yet), but the individual's fetus does face such a risk. In other words, it ensures that a pregnant patient can receive stabilizing care when it is her fetus, not her, that faces a serious health impairment. *Id.* § 1395dd(e)(1)(A)(i) (emphasis added); *see Husky Int'l Elecs., Inc. v. Ritz*, 578 U.S. 355,

366 (2016) (the word "or" is a "disjunctive" term that "expand[s]" rather than "restrict[s]" a statutory provision's reach).

Contrary to Petitioners' assertions, there is no conflict between the obligation to provide abortion care to an individual when necessary to prevent serious harm to the individual, and the obligation to provide stabilizing treatment to an individual when necessary to prevent serious harm to the individual's fetus (even if the individual herself is not at risk of serious harm). And there is certainly no indication in the statutory text that a hospital is required to prioritize the health of a fetus over that of an "individual" experiencing a medical emergency. Thus, EMTALA's reference to an "unborn child" does not vitiate a hospital's obligation to provide abortion care when it constitutes the "[n]ecessary stabilizing treatment" for an "individual" experiencing an emergency medical condition that threatens her own health. *Id.* § 1395dd(b)(1).

The history of EMTALA supports this commonsense interpretation of its text. When Congress originally enacted EMTALA, the definition of "emergency medical condition" did not address a pregnant woman's fetus. *See* Pub L. 99-272, § 9121(b), 100 Stat. at 166. The reference to a fetus was only relevant to consideration of whether "a transfer may pose a threat of [sic] the health and safety of the patient or the unborn child" when a patient was in "active labor." *Id.* The statute thus arguably did not impose any obligations on a hospital when an individual who was *not* in "active labor" presented at an emergency room with a condition that put the health of the fetus, but not the individual's own health, at serious risk.

Congress amended the definition of "emergency medical condition" in 1989 to close this loophole. *See* Pub. L. No. 101-239, § 6211(h), 103 Stat. 2106, 2248

(1989) (updating definition of "emergency medical condition" to its current form). The Conference Report accompanying the amendment made the point clear, stating that the new enactment "clarifi[ed]" the definition by "provid[ing] that 'emergency medical condition' *also* applies to a condition that places in serious jeopardy the health of the woman *or* her unborn child." H.R. Rep. No. 101-386, at 838 (1989) (Conf. Rep.) (emphases added). Thus, the history of EMTALA further undermines Petitioners' assertion that an amendment designed to *expand* the scope of hospitals' obligations under EMTALA actually *restricted* the types of care the statute mandates.

II. Laws, Like EMTALA, Enacted Pursuant to Congress's Spending Authority Have the Same Preemptive Effect as All Other Federal Statutes.

A. The Framers Drafted the Spending Clause and the Supremacy Clause to Empower Congress to Pursue "the General Welfare" Without Interference from Hostile States.

Crafted against the backdrop of numerous abuses of state authority under the Articles of Confederation, the Spending Clause and the Supremacy Clause are both critical provisions that enable Congress to fulfill its constitutionally mandated duties.

The Articles of Confederation established a single branch of the federal government, but they neither authorized it to amass its own funds, nor established a mechanism for ensuring federal supremacy. The result was disastrous: the Confederation Congress could only raise money by "requisitions upon the States," *Lane County v. Oregon*, 74 U.S. 71, 76 (1868), yet the

states frequently failed to provide the funds that Congress requested, 26 *Journals of the Continental Congress 1774-1789*, at 299 (Gaillard Hunt ed., 1928). There was little the federal government could do beyond "remind[ing] the states" of their duties. *Id.* As Alexander Hamilton observed, a "most palpable defect of the . . . Confederation [was] the total want of a *sanction* to its laws." *The Federalist No. 21*, at 138 (Clinton Rossiter ed., 1961). Without a supreme federal power overseeing the states, James Madison asserted, our system of government would be an "inversion of the fundamental principles of all government; it would have seen the authority of the whole society everywhere subordinate to the authority of the parts; it would have seen a monster, in which the head was under the direction of the members." *The Federalist No. 44*, at 287 (Clinton Rossiter ed., 1961).

The Framers gathered in Philadelphia in 1787 to correct these "vices" resulting from the lack of "effectual controul in the whole over its parts." 1 *The Records of the Federal Convention of 1787*, at 167 (Max Farrand ed., 1911). They wrote the Taxing and Spending Clause to provide Congress with the power "[t]o lay and collect Taxes, Duties, Imposts and Excises," and "to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1. Meanwhile, the Supremacy Clause created a "rule of decision" that barred courts from "giv[ing] effect to state laws that conflict with federal laws." *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 324 (2015) (citing *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 210 (1824)). Together, these provisions empower Congress to fund programs that further the "general Welfare of the United States," U.S. Const. art. I, § 8, cl. 1, and to condition that funding on compliance with the "supreme Law of the Land," *id.* art. VI, cl. 2.

B. This Court Has Consistently Held that Statutes Enacted Pursuant to the Spending Clause Must Be Treated as the "Supreme Law of the Land."

Statutes enacted pursuant to the Spending Clause are thus entitled to the same preemptive effect under the Supremacy Clause as those passed pursuant to Congress's other enumerated powers. Consistent with the history of those constitutional provisions, this Court has never singled out Spending Clause legislation for differential treatment in its preemption analysis.

One way Congress exercises its Spending Clause authority is by offering funds to states, localities, and private entities, and "condition[ing] those offers on compliance with specified conditions." *NFIB v. Sebelius*, 567 U.S. 519, 537 (2012); *see, e.g.*, *Oklahoma v. U.S. Civ. Serv. Comm'n*, 330 U.S. 127 (1947); *King v. Smith*, 392 U.S. 309 (1968); *Rosado v. Wyman*, 397 U.S. 397 (1970); *College Savs. Bank v. Fla. Prepaid Postsecondary Ed. Expense Bd.*, 527 U.S. 666, 686 (1999). This Court has made clear that "[t]hese offers may well induce [funding recipients] to adopt policies that the Federal Government itself could not impose." *NFIB*, 567 U.S. at 537; *see, e.g.*, *South Dakota v. Dole*, 483 U.S. 203, 205-06 (1987) (conditioning disbursement of federal highway funds on states raising their drinking age). The broad leeway Congress enjoys in this arena is tempered by the voluntary nature of funding conditions—as this Court has said, parties can "exercise their choice" whether or not to accept federal funding, "much in the nature of a contract." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). *But see Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166, 178-80 (2023) (noting limitations of contract analogy).

Yet once Congress clearly articulates the conditions of funding and a party accepts them, those conditions attain the force of federal law, and any state law that conflicts with them must give way pursuant to the Supremacy Clause. Federal funding recipients are not permitted to flout the obligations that they agree to fulfill when they accept money from the nation's Treasury, depriving the United States of the benefit of its bargain. *See NFIB*, 567 U.S. at 576-78. To strip federal spending laws of their preemptive effect would vitiate the concept of federal supremacy: if states decided that they did not like the terms of a federal grant, they could nullify that grant by enacting a law barring compliance with its terms. In other words, states could dictate federal policy.

This case illustrates the point. By criminalizing compliance with EMTALA, Idaho has attempted to make it impossible for hospitals to accept federal Medicare funds because such funding is contingent on compliance with EMTALA's substantive provisions. *See* 42 U.S.C. § 1395cc(a)(1)(I)(i). In other words, Idaho has purportedly disqualified its hospitals from participation in a major federal health care program—a program in which ninety-eight percent of all providers in the United States participate, *see* Ctrs. for Medicare & Medicaid Servs., *Annual Medicare Participation Announcement* 1 (2024), https://www.cms.gov/medicare-participation (data for calendar year 2023), and that Congress said should be available to "[*a*]*ny* provider of services," 42 U.S.C. § 1395cc(a)(1) (emphasis added).

This Court has concluded that state laws that were even less disruptive to federal policy were preempted by federal Spending Clause legislation. For instance, in *Lawrence County v. Lead-Deadwood School District No. 40-1*, 469 U.S. 256 (1985), this Court held that a South Dakota statute that limited

the discretion of local-government recipients of federal funding was preempted by a Spending Clause statute that expressly authorized recipients to "use the payment for *any* governmental purpose." *Id.* at 258-59 (quoting 31 U.S.C. § 6902(a)) (emphasis added). Critically, unlike Idaho's law here, the South Dakota statute did not make it impossible for funding recipients to accept federal money at all; rather, it simply imposed conditions on their use of that funding that conflicted with the federal "objective of ensuring local governments the freedom and flexibility to spend the federal money as they saw fit." *Id.* at 263. That was enough for this Court to step in: it held that the South Dakota statute violated the Supremacy Clause.

Lawrence County is consistent with a long line of cases in which this Court has repeatedly applied the Supremacy Clause to give preemptive force to congressional legislation under the Spending Clause, ensuring that states do not act in conflict with federal law. *See, e.g.*, *Wos*, 568 U.S. at 636 (holding that Medicaid's anti-lien provision preempted state statute mandating percentage of tort recoveries be paid to the state); *Ahlborn*, 547 U.S. at 279-80 (holding that federal Medicaid law preempted state laws related to settlement-agreement liens); *Blum*, 457 U.S. at 138 (holding that conditions attached to federal funding of state emergency assistance program preempted state program regulations). This is true both in cases involving funding disbursed directly to states, and in those cases—like this one—in which Congress has granted funding to private actors as well.

Petitioners and their *amici* protest that Spending Clause statutes do not constitute "binding federal laws" entitled to preemptive effect because statutes enacted pursuant to that enumerated power are not

immediately and universally binding—that is, spending conditions have "no force unless accepted." Moyle Br. 50; *see* Idaho Br. 21. Yet that is precisely the point: the Constitution empowers Congress to give potential funding recipients the option whether or not to accept federal money and the conditions that come with it. States do not have the power to take that option away. *See Mut. Pharm. Co. v. Bartlett*, 570 U.S. 472, 488 (2013) (holding that "the option of ceasing to act" cannot "defeat[] a claim of impossibility" under this Court's preemption doctrine).

The Supremacy Clause thus ensures that when Congress "provide[s] for the . . . general Welfare of the United States," U.S. Const. art. I, § 8, cl. 1, states cannot substitute their own policies for those adopted by the democratic body charged with representing the nation as a whole. *See Helvering v. Davis*, 301 U.S. 619, 645 (1937) ("When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the states."). As this Court recently put it, states cannot nullify Congress's "broad power under the Spending Clause of the Constitution to set the terms on which it disburses federal funds." *Cummings v. Premier Rehab Keller, PLLC*, 142 S. Ct. 1562, 1568 (2022). That is precisely what Idaho has attempted to do through its near-total abortion ban.

* * *

When this Court ruled that there is no constitutional right to abortion in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022), it neither authorized nor outlawed the procedure, instead, "leav[ing] the issue for the people and their elected representatives to resolve through the democratic process in the States or Congress." *Id.* at 338. Though in some cases state legislatures will have authority to make those judgments, when Congress has passed a law bearing on

abortion, enacted through *any* of its constitutionally enumerated powers, conflicting state laws must give way under the Supremacy Clause. Accordingly, to the extent that Idaho's near-total abortion ban prevents hospitals from providing abortion as the stabilizing treatment required by EMTALA, it is preempted.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the district court.

Respectfully submitted,

ELIZABETH B. WYDRA
BRIANNE J. GOROD*
MIRIAM BECKER-COHEN
CONSTITUTIONAL
ACCOUNTABILITY CENTER
1200 18th Street NW, Suite 501
Washington, D.C. 20036
(202) 296-6889
brianne@theusconstitution.org

Counsel for Amici Curiae

March 28, 2024 * Counsel of Record

APPENDIX:
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