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,
Respondent.

State of IDAHO,
Petitioner,

v.

UNITED STATES,
Respondent.

ON WRIT OF CERTIORARI BEFORE JUDGMENT TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR CALIFORNIA, NEW YORK, ARIZONA, COLORADO, CONNECTICUT, DELAWARE, HAWAI'I, ILLINOIS, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW MEXICO, NORTH CAROLINA, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, WASHINGTON, AND WISCONSIN, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTRODUCTION AND INTEREST OF AMICI CURIAE

Amici States of California, New York, Arizona, Colorado, Connecticut, Delaware, Hawai'i, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin and the District of Columbia submit this brief in support of respondent the United States of America and affirmance of the preliminary injunction against enforcement of Idaho's near total ban on abortion to the extent it conflicts with the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. Amici own and operate hospital systems subject to EMTALA, and employ healthcare personnel, oversee hospitals, and license and regulate the many healthcare providers operating within those hospital systems. Amici thus have a distinctive perspective, informed by experience, on the proper interpretation of EMTALA and a strong interest in ensuring adherence to the obligations arising under the statute. Amici also have a strong interest in protecting the rights of their residents who need emergency medical care while present as students, workers, or visitors in Idaho and other States in which similar abortion bans are in effect. In addition, allowing States to prohibit emergency medical care of any kind that is required under EMTALA places unwarranted strains on the healthcare systems of many amici States.[1]

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[1] Because the question presented to this Court is not limited to the specifics of Idaho's law but rather contemplates any "state laws" that "prohibit abortions," Br. of Pet'r Idaho Legislature *i* (Dkt. No. 23-727) (Legislature Br.), amici States' discussion is not limited to Idaho.

Since it was first enacted in 1986, EMTALA has been a crucial tool in ensuring that everyone who comes to a hospital emergency department receives an appropriate medical screening and that individuals with emergency medical conditions are not transferred or discharged until they receive medical treatment necessary for stabilization. The district court in this case correctly concluded that the emergency care required by EMTALA will include abortion care when a pregnant individual has a qualifying emergency medical condition and abortion is necessary to prevent serious harm to the pregnant individual's health, or to prevent a serious impairment to a bodily function of the pregnant individual or serious dysfunction of an organ or body part. *See* 42 U.S.C. § 1395dd(e)(1)(A). The Idaho law at issue, however, criminalizes abortion care in nearly all situations, including when pregnant patients experience emergency medical conditions and require abortion care to prevent serious harm to their health. Idaho Code § 18-622. The statute authorizes abortion care only when "necessary to prevent" the patient's "death," to "remov[e] . . . an ectopic or molar pregnancy," or where, within the first trimester, the patient obtains a police report that the pregnancy resulted from "rape or incest." *Id*. §§ 18-622(2)(a)(i), 18-604(1)(c), 18-622(2)(b).

Petitioners maintain that EMTALA places no obligation on Idaho's hospitals to provide emergency abortion care in circumstances other than those specifically authorized in Idaho's statute. Amici submit this brief to explain, on the basis of their experience, that the plain text of EMTALA and longstanding regulatory and judicial interpretations of the statute require hospitals to provide emergency abortion care as necessary stabilizing treatment in circumstances beyond those permitted by Idaho's law. The brief also offers amici's unique

perspective on the significant harms to patient health and healthcare systems that will occur if the emergency abortion care required by EMTALA is prohibited in Idaho or any other State.

SUMMARY OF ARGUMENT

I. EMTALA requires hospitals with emergency departments that participate in Medicare to provide stabilizing treatment to an individual with an emergency medical condition before transferring or discharging the individual, subject to several exceptions not relevant here. EMTALA has long been interpreted by both the federal executive branch and federal courts to require treatment of pregnancy-related emergency medical conditions, including when abortion is the necessary stabilizing treatment.

Contrary to petitioners' arguments, this longstanding interpretation accords with the statute's text, and does not ignore EMTALA's references to active labor as an emergency medical condition stabilized by delivery or to an emergency medical condition that may endanger the health of a fetus. Those distinct statutory references require treatment in circumstances that might not otherwise fit within the definition of emergency medical condition, including active labor in healthy pregnancies and when the pregnant individual's medical condition threatens only the health of the fetus. However, where the pregnant individual's medical condition threatens both the individual's health and the health of the fetus, EMTALA leaves the choice of necessary treatments, including abortion, to the pregnant individual, who may consent or withhold consent to any proposed treatment.

II. The experience of amici States as both operators and regulators of healthcare systems confirms that allowing state abortion bans to override EMTALA's narrow but critical protection for pregnant patients who require emergency abortion care to prevent serious harm to their health will cause pregnant patients to suffer grave injuries and death, and will undermine the delivery of healthcare nationwide.

State abortion bans like Idaho's prohibit providers from performing emergency abortions even when the providers deem the treatment to be medically necessary and required under EMTALA. Such bans also deter treatment by creating ambiguity regarding the legality of emergency abortion care. Pregnant patients denied or forced to wait for necessary emergency care will suffer serious and sometimes irreparable harms including organ damage, infertility, limb amputations, and even death.

In addition, the risk of criminal prosecution or professional liability associated with providing emergency abortion care is driving healthcare providers to leave States with near total abortion bans, and forcing hospital systems to reduce or close their obstetrical and gynecological departments. As a result, patients in these States are losing access to a host of care, including primary care, general reproductive care, obstetrical care, and specialist and emergency care for complex and high-risk pregnancies. This reduced access to care risks worse outcomes for maternal and infant health, and for public health more generally.

Many amici States have experienced a significant rise in out-of-state patients seeking abortion care, including emergency care, following the enactment of restrictive abortion laws. Allowing certain States to

undermine EMTALA's requirements for stabilizing emergency care and protection against patient dumping will force many pregnant patients to travel to amici States for emergency abortion care, further burdening already overwhelmed healthcare systems. Hospitals in many amici States are already experiencing strains, resulting in overcrowding, long wait times, and staff shortages, particularly in rural and underserved areas, all of which can affect morbidity and mortality. Providing medical treatment to additional patients who require emergency abortion care, and who are likely to be facing heightened health risks as a result of being denied such care in their home States, will aggravate these existing healthcare stresses, threatening worse health outcomes for everyone who seeks emergency care.

ARGUMENT

I. EMTALA REQUIRES ABORTION CARE WHEN NECESSARY TO STABILIZE PATIENTS EXPERIENCING EMERGENCY PREGNANCY-RELATED CONDITIONS.

EMTALA applies to any hospital that operates an emergency department and participates in Medicare—criteria met by virtually every hospital in the country.[2] Under EMTALA, if "any individual" arrives at a hospital's emergency department seeking examination or treatment, the hospital must provide an appropriate medical screening to determine whether an emergency medical condition exists. 42 U.S.C. § 1395dd(a). If the screening indicates the individual has an emergency medical condition, the hospital cannot transfer or discharge that individual until it provides, "within the staff and facilities available at the hospital," "treatment as may be required to stabilize the medical condition," unless the transfer is specifically authorized by the statute. *Id.* § 1395dd(b)-(c); *see* 42 C.F.R. § 489.24(d)(1)(i) (EMTALA requires stabilizing treatment "[w]ithin the capabilities of the staff and facilities available at the hospital"). The hospital may also admit the patient as an inpatient in good faith to stabilize the emergency medical condition. 42 C.F.R. § 489.24(d)(2)(i).

An "emergency medical condition" is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the

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[2] *See* Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians*, 14 Baylor Univ. Med. Ctr. Proc. 339, 340 (2001); Nathan

(*continues on next page*)

absence of immediate medical attention could reasonably be expected to result in" (i) placing the health of the individual in serious jeopardy, or with respect to a pregnant individual, the health of the individual or the fetus, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. 42 U.S.C. § 1395dd(e)(1)(A). Stabilizing the emergency medical condition involves providing "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." *Id.* § 1395dd(e)(3)(A). An emergency medical condition also exists with respect to a pregnant individual who is in active labor and having contractions, when there is inadequate time for a safe transfer before delivery or transfer before delivery may pose a threat to the health or safety of the pregnant person or the fetus. *Id.* § 1395dd(e)(1)(B). Stabilizing the pregnant individual in this circumstance may include delivery. *Id.* § 1395dd(e)(3)(B).

There are many pregnancy-related emergency medical conditions distinct from active labor that will cause pregnant patients to die or suffer severe harm (such as organ damage or fertility loss) unless they

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S. Richards, *Judicial Resolution of EMTALA Screening Claims at Summary Judgment*, 87 N.Y.U. L. Rev. 591, 601 & n.52 (May 2012). (For sources available on the internet, full URLs appear in the Table of Authorities.)

receive immediate abortion care.[3] The need for emergency abortion care can arise from a range of medical conditions, including when the placenta separates from the uterine wall and causes the pregnant patient to hemorrhage (placental abruption); the amniotic sac breaks before fetal viability (premature rupture of membranes); or the pregnant patient's blood pressure prior to viability becomes so high that they are at risk of seizure, stroke, kidney failure, and other harms (periviable severe preeclampsia).[4] These conditions all trigger EMTALA's obligation to provide stabilizing care since in the absence of immediate treatment, all of them would reasonably be expected to result in serious jeopardy to the pregnant individual's health, serious impairment to bodily functions, or serious dysfunction of a bodily organ. *See id.* § 1395dd(e)(1)(A). Absent several exceptions not relevant here, including when the medical benefits to the individual of transfer outweigh associated risks, EMTALA mandates that an individual with such a condition cannot be transferred or discharged until the hospital provides stabilizing treatment. *See id.* § 1395dd(b)-(c).

Numerous agencies and offices of the federal government, across administrations, as well as federal

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[3] *See* Am. Coll. of Obstetricians & Gynecologists, *Facts Are Important: Abortion Is Healthcare* (n.d.) ("Pregnancy complications . . . may be so severe that abortion is the only measure to preserve a woman's health or save her life."); Reuters Fact Check, *Termination of pregnancy can be necessary to save a woman's life, experts say*, Reuters (Dec. 27, 2021).

[4] *See, e.g.*, Am. Coll. of Obstetricians & Gynecologists, *Preeclampsia and High Blood Pressure During Pregnancy* (last updated Apr. 2022); Am. Coll. of Obstetricians & Gynecologists, *Bleeding During Pregnancy* (last updated May 2021); Joint App. 627-629.

courts throughout the country, have long interpreted EMTALA to require treatment for emergency conditions relating to pregnancy and have concluded that necessary stabilizing treatment required by EMTALA may include emergency abortion care. More than a decade ago, in the context of federal conscience refusal laws that generally allow a physician to refuse to perform an abortion, the U.S. Department of Health and Human Services (HHS) clarified, in amending a rule implementing such laws, that hospitals remain bound by EMTALA and its requirement to provide abortion care in appropriate circumstances.[5] Likewise, in September 2021, Centers for Medicare and Medicaid Services (CMS) issued guidance on EMTALA restating that emergency medical conditions include pregnancy-related conditions and describing required stabilizing treatment as including abortion care when medically indicated.[6] In addition, HHS's Office of Inspector General has brought enforcement actions against hospitals for EMTALA violations involving pregnancy-related emergency medical conditions. *See, e.g.*, *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1367-76 (5th Cir. 1991) (affirming enforcement action against

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[5] *See Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9,968, 9,973 (Feb. 23, 2011).

[6] *See* Mem. from Dirs., Quality, Safety & Oversight Grp. & Survey & Operations Grp., CMS, to State Survey Agency Dirs. (Sept. 17, 2021) (as revised with respect to enforcement Oct. 3, 2022).

hospital where pregnant individual presented with severe hypertension).[7]

Most recently, in July 2022, CMS issued guidance reiterating EMTALA's obligations regarding patients who are pregnant or experiencing pregnancy loss.[8] The CMS guidance restates EMTALA's requirement that determinations regarding whether an individual has an emergency medical condition and, if so, what stabilizing treatment is needed before transfer or discharge, are medical determinations for which the treating physician is responsible. The guidance also notes that numerous pregnancy-related conditions may constitute emergency medical conditions under EMTALA, including emergent hypertensive disorders like preeclampsia with severe features, ectopic pregnancy, or pregnancy loss complica-

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[7] *See also* Dep't of Health & Hum. Servs. & Dep't of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2019*, at 45 (2020) (describing enforcement action involving pregnant individual with preeclampsia); Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Semi-Annual Report to Congress: April 1 – September 30, 2015*, at 37 (2015) (same, pregnant individual with abdominal and lower back pain symptoms); Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Semi-Annual Report to Congress: April 1, 2007 – September 30, 2007*, at 26 (2007) (same, symptoms of vaginal bleeding, cramps, and decreased fetal movement); Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Semi-Annual Report to Congress: October 1, 1999 – March 31, 2000*, at 32-33 (2000) (same, symptom of sharp abdominal pain); Br. of United States at 16 n.2 (cataloguing violations since 2010 where hospitals failed to stabilize emergency medical conditions where the necessary care was abortion care).

[8] *See* Mem. from Dirs., Quality, Safety & Oversight Grp. & Survey & Operations Grp., CMS, to State Survey Agency Dirs. (July 11, 2022) (as revised with respect to enforcement Aug. 25, 2022).

tions. And the guidance reminds hospitals and physicians that if the treating physician determines that abortion is the appropriate stabilizing medical treatment for an emergency medical condition, EMTALA requires that a hospital offer that treatment if the hospital has the capability to provide such treatment.

Courts throughout the country, too, have repeatedly concluded that pregnancy-related emergency conditions, including those that require treatment by abortion, fall within the scope of EMTALA. *See, e.g.*, *Morales v. Sociedad Española de Auxilio Mutuo y Beneficencia*, 524 F.3d 54, 55-62 (1st Cir. 2008) (ectopic pregnancy); *Morin v. Eastern Me. Med. Ctr.*, 779 F. Supp. 2d 166, 168-69, 185 (D. Me. 2011) (16-week-pregnant patient having contractions without fetal cardiac activity); *McDougal v. Lafourche Hosp. Serv. Dist. No. 3*, No. 92-cv-2006, 1993 U.S. Dist. LEXIS 7381, at *1 (E.D. La. May 24, 1993) (pregnant patient with vaginal bleeding). Courts have also consistently interpreted EMTALA as requiring hospitals to provide abortion services when needed to stabilize an emergency medical condition. *See, e.g., Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F. Supp. 2d 696, 712-18 (E.D. Mich. 2009); *New York v. U.S. Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019). And numerous courts have held that patients of physicians who perform abortions must be admitted to a hospital's emergency department under EMTALA regardless of whether the treating physician has admitting privileges at the hospital.[9] Under the

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[9] *See, e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 787-88 (7th Cir. 2013); *June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 64 (M.D. La. 2017), *rev'd on other grounds sub*

(*continues on next page*)

reasoning of these decisions, if a patient arrives at the emergency department with an incomplete abortion, EMTALA requires that the patient receive stabilizing emergency abortion care. *See June Med. Servs.*, 250 F. Supp. 3d at 62, 64. For this reason, one court concluded that clinics providing abortion services need not have transfer agreements with hospitals. *EMW Women's Surgical Ctr. v. Glisson*, No. 17-CV-00189, 2018 U.S. Dist. LEXIS 208844, *42-43 (W.D. Ky. Sept. 28, 2018), *rev'd in part on other grounds*, 978 F.3d 418 (6th Cir. 2020).

Liability for failure to provide stabilizing treatment is not dependent on the motive of the physician or hospital. *See Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 253 (1999) (per curiam); *Burditt*, 934 F.2d at 1373 (same, failure to effect proper transfer). Courts have long interpreted EMTALA as protecting patients from "being turned away from emergency rooms for non-medical reasons." *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996). Thus, "courts have declined to read exceptions into EMTALA's mandate," including exceptions allowing transfers based on individual physicians' religious, moral, or ethical refusal to provide specified stabilizing treatment. *New York*, 414 F. Supp. 3d at 537 (collecting cases); *see Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (observing that EMTALA's plain text prohibits a hospital from refusing treatment based on "political or cultural opposition").

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nom., *June Med. Servs. LLC v. Gee*, 905 F.3d 787 (5th Cir. 2018), *rev'd sub nom.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 899-900 (W.D. Tex. 2013), *rev'd on other grounds*, 748 F.3d 583 (5th Cir. 2014).

Petitioners argue that EMTALA does not require emergency abortion care. Br. of Pet'r Idaho 32-35, 37 (Dkt. No. 23-727) (Idaho Br.); Legislature Br. 2, 7, 22-26. That argument ignores—and cannot explain—that regulators and courts have long interpreted EMTALA to require emergency abortion care in certain circumstances. As the district court correctly concluded, EMTALA requires hospitals to offer emergency abortion care if they have the capability to do so, when an abortion is necessary to avoid serious harm to the pregnant patient's health. (*See* Joint App. (J.A.) 638-639, 668-669 (denying motion for reconsideration).)

Instead of grappling with that body of precedent, enforcement history, or federal guidance interpreting EMTALA to require all forms of necessary stabilizing treatment, including abortion care, petitioners focus on certain references in EMTALA to delivery in cases of active labor and to conditions that endanger the health of a fetus. Idaho Br. 8, 17, 32-33 (citing *Texas v. Becerra*, 89 F.4th 529, 542 (5th Cir. 2024)); Legislature Br. 2, 6. Petitioners misunderstand the meaning of those provisions. Contrary to Petitioners' argument, these provisions do not foreclose abortion care; instead, they protect certain pregnant individuals from being denied treatment or transferred while in labor and allow for emergency stabilizing treatment even when only the health of the fetus is endangered.

Specifically, EMTALA defines emergency medical condition to include *either* a medical condition that is likely to result in serious harms if not immediately treated "*or*" the situation of a pregnant person having contractions, where there is inadequate time to effect a safe transfer before delivery or the transfer poses a threat to health and safety. 42 U.S.C. § 1395dd(e)(1)(A)-(B) (emphasis added). EMTALA likewise gives the

terms "to stabilize" and "stabilized" alternative meanings: either treatment to avoid deterioration of the medical condition or, with respect to a pregnant individual having contractions, delivery. *Id.* § 1395dd(e)(3)(A)-(B). Thus in *Burditt*, 934 F.2d at 1368-70, the court separately analyzed both the pregnant individual's medical condition and the imminence of delivery in determining whether an emergency medical condition existed. The references to contractions and delivery are specifically included in EMTALA—the Emergency Medical Treatment *and* Labor Act—because the statute might otherwise not apply to active labor in healthy pregnancies. Having contractions may not meet the definition of "emergency medical condition" in all circumstances because labor is not generally expected to result in "serious harm" absent immediate medical treatment. Likewise, to deliver in active labor might not ordinarily meet the definition of "to stabilize" because delivery does not avoid "material deterioration" of the pregnancy resulting from an unsafe hospital transfer. For this reason, and because nothing in EMTALA excludes any conditions or categories of medical care from the statute's requirements, it is unremarkable that EMTALA references labor *and* delivery to expand the circumstances in which care is required. But that does not signal that abortion care is unavailable as a form of stabilizing treatment for emergency medical conditions.

Nor does EMTALA's definition of emergency medical condition prioritize the treatment needs of the fetus over the needs of the pregnant person in situations not involving active labor, as petitioners contend. *See* Idaho Br. 4, 8-9, 17, 20, 37; Legislature Br. 2, 4-5, 18. Petitioners point to the fact that one of the three situations included in the definition of emergency medical

condition in paragraph (A) of § 1395dd(e)(1)—the paragraph concerned with medical conditions that result in serious harms—refers to a medical condition that places the health of the pregnant person or the fetus in serious jeopardy if not immediately treated.[10] 42 U.S.C. § 1395dd(e)(1)(A)(i). That language does not mean that EMTALA forecloses any treatment for a pregnant patient's emergency medical condition that would put the fetus in jeopardy.

Several provisions of EMTALA make clear that the focus of EMTALA's screening and stabilizing requirements is the medical condition of the "individual." Thus, section 1395dd(b)(1) requires necessary stabilizing treatment only when an "*individual* has an emergency medical condition" (emphasis added), and the text and structure of EMTALA as a whole makes clear that the "individual" is the pregnant person, and not the fetus: Sections 1395dd(b)(2) and (3) provide that a hospital meets its obligations under EMTALA when an "individual" refuses treatment or transfer after being informed of risks and benefits. Similarly, sections 1395dd(c)(1)(A)(ii) and (c)(2)(A) juxtapose the effect of transfer on the "individual" with, in the case of labor, the effect on the "unborn child." *See also* 1 U.S.C. § 8(a) (in federal statutes, the term "individual" includes infants born alive). EMTALA's reference to a fetus in this part of the definition of "emergency medical condition" (§ 1395dd(e)(1)(A)(i)) simply recognizes that in some cases the pregnant individual's medical condition may place the health of the fetus—but not (yet) the

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[10] An emergency medical condition that is not active labor is otherwise defined without reference to the fetus, i.e., an individual's medical condition that could reasonably lead to serious dysfunction of any bodily organ or bodily part. *See* § 1395dd(e)(1)(A)(ii)-(iii).

pregnant person—in serious jeopardy. EMTALA would require stabilizing treatment of the pregnant individual's medical condition in that circumstance, even if the medical condition did not (yet) pose a risk of serious harm to the pregnant person's health.

In circumstances where both the pregnant individual and the fetus simultaneously face significant harm if the pregnant individual's condition is not stabilized, the text of EMTALA resolves any potential conflict regarding necessary treatments by leaving the choice of whether to pursue stabilizing abortion care or continue gestation to the pregnant individual Under the text of EMTALA, the pregnant individual can grant or refuse consent for either treatment. *See* 42 U.S.C. § 1395dd(b)(2) (hospital's duty to provide stabilizing treatment is met where it offers the treatment, explains the risks and benefits, and the individual refuses to consent). EMTALA thus treats abortion the same as any other stabilizing medical treatment and places the final decision regarding recommended treatment with the pregnant individual.

This interpretation of EMTALA is confirmed in two respects by the legal context in which EMTALA was enacted. First, both the common law and the Constitution protect a competent adult's right to consent to or refuse medical treatment. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 2278-79 (1990); *see also id.* at 269 (noting that "'no right is held more sacred, or is more carefully guarded, by the common law'" than the right to bodily integrity (quoting *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891))); *Rochin v. California*, 342 U.S. 165 (1952) (criminal defendant's constitutional right to liberty was violated by obtaining evidence

through forced stomach pumping without consent).[11] Second, when EMTALA was enacted in 1986 and shortly thereafter amended to reflect its current structure, this Court had interpreted the Constitution to protect the right to access abortion, particularly when a pregnant individual's health was at stake. *See City of Akron v. Akron Ctr. for Reproductive Health,* 462 U.S. 416, 427 (1983); *Roe v. Wade*, 410 U.S. 113, 153 (1973). This context confirms that EMTALA could not have been intended to codify an exemption to its guarantee of emergency medical care by elevating an interest in fetal life over a pregnant patient's health; instead, it necessarily left such prioritization decisions to the pregnant patient suffering from an emergency medical condition. Under EMTALA, abortion care may be required when necessary to stabilize an emergency medical condition, unless the pregnant individual refuses consent or the medical benefits to the individual from transfer to another medical facility for treatment outweigh any associated risks. 42 U.S.C. § 1395dd(b)-(c).

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[11] The law of Idaho reflects these principles as well. *See Peckham v. Idaho State Bd. of Dentistry*, 154 Idaho 846, 853 (2013) (absent an emergency, healthcare provider's failure to obtain informed consent "would be a grave affront to [patients'] rights to self-determination and bodily autonomy"); Idaho Code §§ 39-4501 to 39-4508 (medical informed consent law); *see also* Idaho Code § 39-4509 (advanced directives law) ("The legislature recognizes the established common law and the fundamental right of competent persons to control the decisions relating to the rendering of their health care.").

II. PROHIBITING EMERGENCY ABORTION CARE HARMS PREGNANT PATIENTS AND HEALTH SYSTEMS.

Allowing States to override EMTALA's narrow but critical baseline protection for pregnant patients who require emergency abortion care to safeguard their health will result in multiple harms. First, pregnant patients denied emergency abortion care will die or suffer irreversible injuries. Second, healthcare providers will leave those States, resulting in diminished health system capacity and worse overall patient care. And third, pregnant patients from those States will seek emergency abortion care in amici States, which may cause further strain to many amici States' already overwhelmed health systems.

A. Prohibiting Emergency Abortion Care Causes Patient Suffering, Injury, and Death.

Some pregnant patients experience emergency medical conditions that will cause them to die or suffer severe harm to their health, unless they receive immediate abortion care.[12] Pregnancy complications that can be emergency medical conditions include placental

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[12] *See* Am. Coll. of Obstetricians & Gynecologists, *Facts Are Important: Abortion Is Healthcare*, *supra* ("Pregnancy complications . . . may be so severe that abortion is the only measure to preserve a woman's health or save her life."); Reuters Fact Check, *Termination of pregnancy can be necessary to save a woman's life, experts say*, Reuters (Dec. 27, 2021), *supra.*

abruption; premature rupture of membranes; and periviable severe preeclampsia.[13]

Amici States have long understood that abortion care is sometimes necessary to stabilize an emergency medical condition, and hospitals in nearly all amici States regularly provide such care.[14] Other States, however, including Idaho, have recently banned abortion care without allowing a sufficient exception for medical emergencies—if they offer any health exception at all.[15] Those abortion bans deprive pregnant patients of emergency abortion care covered by EMTALA in two

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[13] *See, e.g.*, Am. College of Obstetricians & Gynecologists, *Preeclampsia and High Blood Pressure During Pregnancy*, *supra*; Am. Coll. of Obstetricians & Gynecologists, *Bleeding During Pregnancy*, *supra*; Johns Hopkins Med., *Pregnancy Complications* (n.d.); J.A. 627-629.

[14] Some hospitals in amici States that do not regularly provide abortion care in non-emergency settings explicitly allow abortion care when it is the appropriate treatment for an emergency condition and therefore required under EMTALA. *See* Wash. State Dep't of Health, *Hospital Reproductive Health Services for Lourdes Hospital*, at 1 (Sept. 3, 2019); Wash. State Dep't of Health, *Hospital Reproductive Health Services for Virginia Mason Memorial Hospital*, at 1–2 (Aug. 30, 2019); Wash. State Dep't of Health, *Hospital Reproductive Health Services for Ferry County Memorial Hospital*, at 1–2 (Aug. 29, 2019).

[15] Abortion is currently banned in fourteen States, and extremely restricted in several more States. *See* Ctr. for Reprod. Rts., *After* Roe *Fell: Abortion Laws by State* (n.d.) (last accessed Feb. 20, 2024). In certain other States, abortion bans and restrictions are presently enjoined pursuant to ongoing litigation. *Id*. Of the States with abortion bans, gestational limits, or viability limits, six do not provide any express exception for when the pregnant person's health is at risk. *See* Ivette Gomez et al., *Abortions Later in Pregnancy in a Post*-Dobbs *Era*, Kaiser Family Found., Fig. 5 (Feb. 21, 2024).

respects. First, they prohibit providers from offering emergency abortion care by authorizing abortion care only in situations narrower than those contemplated by EMTALA. Second, they deter providers from offering emergency abortion care that may in fact be authorized because it is often unclear when a pregnant patient will be deemed to satisfy a ban's exception. That is in part because "much of medicine is a gray area" and "most maternal life risks" are not "straightforward."[16] For example, providers may know the overall morbidity and mortality rates of particular emergency medical conditions, but they generally cannot guarantee that a specific patient will experience a specific outcome, nor can they easily discern exactly when a pregnant patient's emergency condition moves from health-damaging to life-threatening. As one expert in reproductive health, explained: "It's not like a switch that goes off or on that says, 'OK, this person is bleeding a lot, but not enough to kill them,' and then all of a sudden, there is bleeding enough to kill them. It's a continuum, so even how someone knows where a person is in that process is really tricky."[17] Given the serious penalties for violating

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[16] Tina Reed, *Defining "Life-Threatening" Can Be Tricky in Abortion Law Exceptions*, Axios (June 28, 2022).

[17] Aria Bendix, *How Life-Threatening Must a Pregnancy Be to End It Legally?*, NBC News (June 30, 2022) (statement of Dr. Lisa Harris, Professor of Reproductive Health and Professor in the Department of Obstetrics and Gynecology at the University of Michigan); *see also* Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of* Roe v. Wade, N. Engl. J. Med. (2022); Erika L. Sabbath et al., *US Obstetrician-Gynecologists' Perceived Impacts of Post-*Dobbs v Jackson *State Abortion Bans*, JAMA Netw. Open (Jan. 17, 2024); Randi Kaye & Stephen Samaniego, *Idaho's murky abortion law is driving doctors out of the state*, CNN (May 13, 2023).

Idaho's abortion ban and other bans like it, and the risk that even good-faith medical judgments will be second-guessed, the ambiguity regarding the legality of emergency abortion care creates a "culture of fear" that deters providers from performing emergency abortions even when they deem them to be medically necessary and required under EMTALA.[18]

Denying stabilizing abortion care when a pregnant patient faces a serious threat to health can result in severe and irreparable injury—including hysterectomy and the loss of fertility, kidney failure, brain injury, and limb amputation—forcing the patient to live "with significant disabilities and chronic medical conditions." (J.A. 621; *see also* J.A. 627-630 & n.3.) For example, a pregnant patient with an emergency medical condition that was not necessarily life-threatening could, if denied stabilizing abortion care, develop "severe sepsis potentially resulting in catastrophic injuries such as septic emboli [infected blood clots] necessitating limb amputations or uncontrollable uterine hemorrhage ultimately

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[18] U.S. Senate Health, Educ., Labor & Pensions Comm., *Impacts of a Post-*Roe *America: The State of Abortion Policy After* Dobbs at 13 (Aug. 1, 2022); *see also* Kavitha Surana, *Their States Banned Abortion. Doctors Now Say they Can't Give Women Potentially Lifesaving Care.*, ProPublica (Feb. 26, 2024); Sabbath et al., *US Obstetrician-Gynecologists' Perceived Impacts of Post-*Dobbs v Jackson *State Abortion Bans*, JAMA Netw. Open, *supra*; Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, 328 JAMA 1691 (Nov. 1, 2022) (explaining, with respect to S.B. 8 in Texas, that it is unclear "whether physicians can intervene to prevent progression to critical scenarios, as is the standard in critical care medicine, or instead, if a physician must withhold evidence-based care until a patient develops an unambiguous emergency with significantly increased morbidity and mortality, such as septic shock and multisystem organ failure").

requiring hysterectomy but [she] could still be alive." (J.A. 629-630 (quoting J.A. 599 (reply declaration of Dr. Emily Corrigan, Idaho-based OBGYN)).) EMTALA requires that stabilizing emergency care be offered to avoid such harms. 42 U.S.C. § 1395dd(e)(1)(A)(ii)-(iii) (emergency medical conditions include conditions that are reasonably expected to cause "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part" if not immediately treated).

Delaying stabilizing abortion care until a doctor has "documentation of an unambiguous threat to life is" likewise "dangerous."[19] "[T]he longer emergency abortions are delayed, the greater the risk that lifesaving interventions might not be effective and pregnant individuals could experience morbidity and mortality."[20] In emergency care generally, "each hour of delayed care increases a patient's likelihood of dying by approximately 4%."[21] That risk may be even higher for pregnant patients, "many" of whom "are young and healthy; thus, they are able to compensate for severe physiologic derangements and might not appear ill until very late

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[19] Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the Dobbs Ruling*, 328 JAMA 1691 (Nov. 1, 2022); *see also* U.S. Senate Health, Educ., Labor & Pensions Comm., *Impacts of a Post-*Roe *America, supra* at 13-15; Sabbath et al., *US Obstetrician-Gynecologists' Perceived Impacts of Post-*Dobbs v Jackson *State Abortion Bans*, *supra* at 3-4; J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion*, N.Y. Times (July 20, 2022).

[20] MacDonald et al., *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, *supra.*

[21] *Id.*

in their course of critical illness."[22] As an obstetrician-gynecologist in Idaho explained, if providers "delay[ ] medical care until we can say an abortion is necessary to prevent death . . . [p]atients will suffer pain, complications, and could die."[23] An obstetrician and fetal surgeon who recently left Texas similarly stated: "It's a very dangerous way of practicing. All of us know some of them will die."[24]

These harms are not hypothetical. To take but one example, a recent study of maternal morbidity at two Texas hospitals following the enactment of S.B. 8, a six-week abortion ban, makes clear the harm of denying or delaying emergency abortion care. The study evaluated pregnant patients at 22 weeks or less gestation who presented at a hospital with certain complications, including preterm premature rupture of membranes, preeclampsia with severe features, and/or vaginal bleeding. The patients were provided with observation-only care until they developed an immediate threat to their life, their fetus no longer had cardiac activity, or they spontaneously went into labor—outcomes that on average took nine days after they presented to the hospital. The rate of serious maternal morbidity for these Texas patients (57%) was nearly double the rate for patients with similar complications in other States who were able to immediately terminate their pregnancies

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[22] *Id.*

[23] Lisa Baumann, *Idaho abortion law one reason hospital won't deliver babies*, AP News (Mar. 23, 2023).

[24] J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion*, *supra.*

(33%).[25] The Texas patients endured hysterectomy, hemorrhage, severe infection, intensive care admission, and hospital readmission, among other harms.[26] Forcing the Texas patients to suffer the harms of denied or delayed emergency abortion care did not correspond to improved perinatal outcomes; all but one of the Texas patients in the study lost their fetus or infant, with the majority dying during labor or within 24 hours of delivery.[27]

Regrettably, too many patients have already suffered because their State's laws forced their providers to deny or delay medically-indicated emergency abortion care.[28] Prohibiting providers from offering medically necessary, evidence-based emergency abortion care to their pregnant patients poses a direct threat to those patients' lives and well-being—precisely the sort of harms that Congress designed and enacted

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[25] 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. Obstetrics & Gynecology 648, 648–50 (2022).

[26] *Id.* at 649.

[27] *Id.*

[28] *See, e.g.*, Sabbath et al., *US Obstetrician-Gynecologists' Perceived Impacts of Post-*Dobbs v Jackson *State Abortion Bans*, *supra*; Daniel Grossman et al., *Care Post-*Roe: *Documenting cases of poor-quality care since the* Dobbs *decision* at 7 (May 2023); Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion.*, ProPublica (Mar. 14, 2023) (identifying in "news articles, medical journal studies and lawsuits . . . at least 70 examples across 12 states of women with pregnancy complications who were denied abortion care or had the treatment delayed since *Roe* was overturned").

EMTALA to avoid. *See* J.A. 623; Response of United States to Stay Application at 24 & n.6.

B. Prohibiting Emergency Abortion Care Harms Healthcare Systems and Overall Patient Care in States with Abortion Bans.

In addition to jeopardizing the health of pregnant patients experiencing medical emergencies, abortion bans like Idaho's undermine healthcare delivery and patient outcomes more broadly by driving obstetrician-gynecologists and other healthcare providers out of the State. This exodus of providers harms the residents of Idaho and other States with abortion bans, and also threatens the health and safety of those residents of amici States who require healthcare while living in or visiting those States. In addition, diminished access to providers encourages out-of-state patients to seek care in amici States, further straining many amici States' healthcare systems. These harms will be exacerbated if States are allowed to override EMTALA's requirements for emergency abortion care.

In Idaho, the abortion ban has already pushed more than 40-60 obstetricians to leave the State or retire—reducing the total number of obstetricians in the State by 22%.[29] This includes over half of Idaho's longtime maternal-fetal medicine specialists, who treat complex and high-risk pregnancies that are most likely to result in the need for emergency care.[30] As a result, there are

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[29] Idaho Physician Well-Being Action Collaborative & Idaho Coalition for Safe Reproductive Health Care, *A Post* Roe *Idaho*, at 2 (Feb. 2024).

[30] Sheryl Gay Stolberg, *As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers*, N.Y. Times (Sept. 6, 2023).

now just four maternal-fetal medicine specialists for the entire State.[31]

The ability to provide abortion care to protect a patient's health when emergencies arise—rather than just to prevent death—likely would improve Idaho's ability to retain healthcare providers. In a 2023 survey of dozens of obstetrician-gynecologists, family practitioners, emergency physicians, and other medical providers in Idaho, 64% reported that they were considering leaving Idaho within the next year because of the abortion ban.[32] But when asked whether "they would stay in Idaho if the legislature modified the existing abortion laws to allow exceptions to preserve the health of the patient (not just 'prevent death')," 96% of the obstetrician-gynecologists who were considering leaving Idaho said that they would "consider staying" or would "very likely stay" if such a change were made.[33] The respondents were surveyed again after the close of Idaho's 2023 legislative session, during which no such health exception was enacted. Fifty-seven percent of those surveyed responded that they were definitely leaving or considering leaving Idaho, including dozens of providers—primarily obstetrician-gynecologists, maternal-fetal medicine specialists, pediatricians,

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[31] *Id.*; *see also* Kaye & Samaniego, *Idaho's murky abortion law is driving doctors out of the state*, *supra*; Kathleen McLaughlin, *No OB-GYNs Left in Town: What Came After Idaho's Assault on Abortion*, The Guardian (Aug. 22, 2023); Christopher Rowland, *A challenge for antiabortion states: Doctors reluctant to work there*, Wash. Post (Aug. 6, 2022).

[32] Idaho Coalition for Safe Reproductive Health Care, *Idaho Physician Retention Survey—May 2023*, at 1 (May 2023).

[33] *Id.*

family physicians, and psychiatrists—who reported definite plans to leave Idaho or retire.[34]

The exodus of providers because of Idaho's abortion ban is harming the ability of hospital systems in Idaho to deliver healthcare beyond abortion care, including emergency care.[35] At least one Idaho hospital has stopped providing all obstetrical services because of the ban, explaining: "[T]he Idaho Legislature continues to introduce and pass bills that criminalize physicians for medical care nationally recognized as the standard of care . . . . Highly respected, talented physicians are leaving. Recruiting replacements will be extraordinarily difficult."[36] Another Idaho hospital will close its labor and delivery and neonatal intensive care unit services in April 2024 due in part to its inability to recruit obstetrician-gynecologists.[37]

Other States with abortion bans are experiencing similar ripple effects, losing their current providers and struggling to recruit new providers. In 2023, these States saw their obstetrical-gynecology and family

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[34] *Id.* at 2-4.

[35] *See, e.g.*, Amanda Sullender, *Idahoans in rural Sandpoint reflect on a year without labor and delivery services*, The Spokesman-Review (Mar. 11, 2024).

[36] Bonner General Health, *Press Release: Discontinuation of Labor & Deliver Services at Bonner General Hospital* (March 17, 2023); *see also* Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Trib. (May 2, 2023) (noting that a second hospital in rural Idaho halted labor and delivery services a few months after Idaho enacted its abortion ban).

[37] Idaho Physician Well-Being Action Collaborative & Idaho Coalition for Safe Reproductive Health Care, *A Post Roe Idaho*, at 2, *supra*.

medicine residency applications drop by 10.5% and 7.4%, respectively.[38] That trend is likely to continue—a recent survey of third-and fourth-year medical students found that 58% of respondents were unlikely to apply to residency in a State with abortion restrictions, irrespective of their planned specialty.[39]

When hospitals close or reduce their capacity to provide obstetrical and gynecological care, patients suffer, exacerbating the need for emergency care. They lose ready access to critical reproductive health services, including gynecologic surgery, gynecologic oncology care, and infertility treatment.[40] Pregnant patients must travel further (including to amici States) for prenatal care and labor and delivery services, often at greater logistical and financial cost.[41] When prenatal care is more difficult to access, rates of serious pregnancy complications, including preterm birth and maternal mortality, increase.[42] Lack of prenatal care is

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[38] Fenit Nirappil & Frances Stead Sellers, *Abortion ban states see steep drop in OB/GYN residency applicants*, Wash. Post (April 21, 2023); Alison Huffstetler et al., *Family Medicine Residency Applications Declined More Precipitously in States With Abortion Restrictions*, Am. Fam. Physician 108(2):132-133 (2023).

[39] Ariana Traub et al., *The* Dobbs *Decision and Its Geographical Effect on Future Physician Training*, Obstetrics & Gynecology 141(5S); p 100s (May 2023).

[40] *See* Am. Coll. of Obstetricians & Gynecologists, *Subspecialties of OB-GYN* (2023).

[41] Julianne McShane, *Pregnant with no OB-GYNs around: In Idaho, maternity care became a casualty of its abortion ban*, NBC News (Sept. 30, 2023).

[42] *Id.*; March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S., 2022 Report* (2022).

also associated with higher rates of neonatal death and low birth weight.[43]

A lack of adequate emergency care for pregnant patients also harms those patients by forcing some of them to travel out of state for emergency abortion care or other medical services. Those patients must absorb greater out-of-pocket expenses and endure the risks of delayed care—including exacerbated complications, more extensive treatment, a higher likelihood of needing emergency room follow-up care, and costs to their emotional and mental health.[44] These burdens are most acutely felt by racial and ethnic minorities, who already have more limited access to healthcare and experience worse outcomes.[45] And the States to which they

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[43] *See, e.g.*, Dep't of Health & Hum. Servs., Office on Women's Health, *Prenatal Care* (last updated Feb. 22, 2021).

[44] *See* Allison McCann, *As Abortion Access Shrinks, Hospitals Fill in the Gaps*, N.Y. Times (Oct. 23, 2023); Laura McCamy, *Over a Year after the Supreme Court Overturned* Roe v. Wade, *the Cost of an Abortion in the US Can Be as Much as $30,000—or as Little as $150*, Bus. Insider (Oct. 21, 2023); Katrina Kimport & Maryani Palupy Rasidjan, *Exploring the emotional costs of abortion travel in the United States due to legal restriction*, Contraception 120:109956 (Apr. 2023); Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28 J. Women's Health 1623, 1623, 1623–24 (2019); Nicole E. Johns et al., *Distance Traveled for Medicaid-Covered Abortion Care in California*, 17 BMC Health Servs. Rsch., at 9 (2017).

[45] Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, Commonwealth Fund (Dec. 14, 2022); Samantha Artiga et al., KFF, *What are the Implications of the Overturning of Roe v. Wade for Racial Disparities?* (July 5, 2022).

travel—typically, amici States—must manage this influx of patients on top of the existing strains to their healthcare systems. *See* Part II.C, *infra*.

Patients likewise suffer when they lose ready access to family practitioners, who deliver obstetric care, pediatric care, geriatric care, and a "range of preventative and urgent care services needed to sustain a healthy community."[46] In Idaho, fourteen family practitioners planned to leave the State by the end of 2023 because of the abortion ban, including twelve who practiced in rural areas, where they were "the foundation upon which . . . patients depend to access health and life preserving care."[47]

According to Dr. James Souza, the chief physician executive for St. Luke's Health System in Boise, because of Idaho's abortion ban, "We're at the beginning of the collapse of an entire system of care . . . . If the momentum doesn't shift, . . . there's no question that there will be bad perinatal outcomes for moms and babies."[48] All of these impacts on health systems will be exacerbated if States are allowed to prohibit stabilizing emergency abortion care.

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[46] Idaho Coalition for Safe Reproductive Health Care, *Idaho Physician Retention Survey—May 2023*, *supra*, at 4.

[47] *Id.*

[48] Kaye & Samaniego, *Idaho's murky abortion law is driving doctors out of the state*, *supra*.

C. Prohibiting Emergency Abortion Care Harms Amici States.

Allowing States like Idaho to eviscerate EMTALA's nationwide guarantee of stabilizing emergency care and protection against patient dumping will drive many pregnant patients to amici States for emergency abortion care to preserve their health. That influx may result in more crowded waiting rooms, increased delays for urgent healthcare services, and overall strains on many amici States' healthcare systems.

State laws restricting abortion care already have forced many pregnant individuals to travel out of state. In the first four months after Texas's six-week abortion ban, S.B. 8, went into effect, the number of Texans seeking abortion care in nearby States increased by 984%, as compared to the same four-month period two years prior.[49] After *Dobbs*, Planned Parenthood clinics in Washington saw a 56% increase in patients from Idaho, and a 36% increase in out-of-state patients overall.[50] In Illinois, the number of out-of-state abortion patients grew by 49%.[51] Colorado's share of out-of-state abortion

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[49] Kari White et al., Tex. Pol'y Evaluation Project, *Out-of-State Travel for Abortion Following Implementation of Texas Senate Bill 8* at 1 (Mar. 2022).

[50] Lauren Gallup & Rachel Sun, *Number of Idaho abortion patients traveling to Washington up 56% after Roe overturned*, OPB (July 10, 2023) (updated July 11, 2023).

[51] Angie Leventis Lourgos, *Illinois abortions surged the year* Roe *fell, with nearly 17,000 patients traveling from other states*, Chic. Trib. (Jan. 11, 2024).

patients doubled between 2021 and 2023.[52] And in California, clinics across the state saw skyrocketing increases in the number of out-of-state patients seeking abortion care, with some clinics seeing four-fold, 500%, and 900% increases in demand.[53] Many other amici States have seen similar increases in demand for abortion care from out-of-state patients.[54]

Some of these out-of-state patients have required emergency abortion care to preserve their health. For example, when a physician in Tennessee was forced by that State's ban to deny abortion care to a pregnant patient at risk of severe preeclampsia—"a serious health emergency" but not one that the physician was confident would be deemed life-threatening—the patient had to travel six hours by ambulance to North Carolina to obtain an abortion.[55] The patient arrived in North Carolina "with dangerously high blood pressure and signs of kidney failure," requiring more critical care than

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[52] John Daley, *Abortion numbers rise sharply in Colorado, driven by out-of-state patients*, Colo. Pub. Radio News (Sept. 11, 2023) (reporting that Colorado had 60 times more patients from Texas seeking abortion care in 2022 than 2019).

[53] Marisa Kendall, *Demand has quadrupled at some California abortion clinics since Roe fell*, Mercury News (Jan. 1, 2023); Karma Dickerson, *More out-of-state patients begin arriving in California for reproductive health services*, Fox 40 News (Sept. 20, 2022); Cindy Carcamo, *A California desert town has long been an abortion refuge for Arizona and Mexico. Now it's overwhelmed*, L.A. Times (July 20, 2022).

[54] *See, e.g.*, Soc'y of Family Planning. *#WeCount Public Report: April 2022 to September 2023* (Feb. 28, 2024).

[55] Laura Kusisto, *Doctors Struggle with Navigating Abortion Bans in Medical Emergencies*, Wall Street J. (Oct. 13, 2022).

if she had been provided an abortion in Tennessee.[56] Anna Zargarian, a patient from Texas, was just 19 weeks pregnant when her water broke, putting her at risk of septic shock and hemorrhage.[57] Her providers in Texas were afraid to treat her until her health had deteriorated to the point that she was at imminent risk of death.[58] Rather than jeopardize her health, she flew to Colorado to obtain an emergency abortion.[59] Likewise, a pregnant patient from Idaho with serious kidney disease urgently needed but was denied an abortion to preserve her health, so she had to leave her family and fly several hours away for care.[60] These are not isolated incidents—Oregon Health & Science University providers report seeing these types of cases "every week."[61]

Forcing pregnant patients to travel out of state for emergency abortion care harms the States to which they travel, which are predominantly amici States. Hospitals in many amici States are already struggling with overcrowding, long wait times, and staff shortages, particularly in rural and underserved areas, all of which

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[56] *Id.*

[57] Eleanor Klibanoff, *Women denied abortions sue Texas to clarify exceptions to the law*, Tex. Tribune (Mar. 7, 2023).

[58] *Id.*

[59] *Id.*

[60] Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Trib., *supra*.

[61] Nicole Rideout, *One year since the overturn of Roe, OB/GYNs report devastating impacts from lack of abortion access*, OSHU News (June 24, 2023).

can impact patient morbidity and mortality.[62] An influx of out-of-state patients requiring emergency abortion care will aggravate existing healthcare stresses, threatening worse health outcomes for all people seeking emergency care. Increasing numbers of out-of-state patients will also make it harder for in-state patients to quickly access needed abortion care, resulting in delays and more invasive and costly procedures later in pregnancy.[63]

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The injunctive relief granted by the district court below is critical to safeguard patient health and preserve the capacity and integrity of healthcare

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[62] *See* WRGB Staff, *New York Ranks Fourth in Longest ER Wait Times, New Study Reveals*, CBS 6 News (Aug. 21, 2023) (updated Aug. 22, 2023) (8 amici States are among top 10 States with the longest emergency room waiting times); Sarai Rodriguez, *Emergency Department (ED) Overcrowding Leads to Worse Health Outcomes*, Patient Engagement HIT (Nov. 14, 2022) (noting that emergency department overcrowding can lead to a 5% increase in mortality rate for patients experiencing medical emergencies); Gabor Kelen et al., *Emergency Department Crowding: The Canary in the Health Care System*, NEJM Catalyst (Sept. 28, 2021) ("The impact of [emergency department] overcrowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented.").

[63] *See* Matt Bloom & Bente Berkland, *Wait Times at Colorado Clinics Hit Two Weeks as Out-of-State Patients Strain System*, KSUT (July 28, 2022) (reporting 100% increase in wait times for abortion care in Colorado clinics since *Dobbs*); Marielle Kirstein et al., Guttmacher Inst., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care* (Oct. 6, 2022) (discussing how the "dramatic increases in caseloads mean clinic capacity and staff are stretched to their limits, resulting in longer wait times for appointments even for residents of states where abortion remains legal").

systems, both in Idaho and amici States. If States are allowed to vitiate EMTALA and prohibit emergency abortion care necessary to preserve a pregnant patient's health to the extent required by EMTALA, countless pregnant patients will suffer serious and sometimes irreparable medical consequences, including organ damage, infertility, and even death; providers will be more likely to flee States with abortion bans, further jeopardizing healthcare delivery and patient outcomes more generally; and patients in need of emergency abortion care will travel to amici States, adding strains to already overburdened healthcare systems and undermining their residents' care.

CONCLUSION

The preliminary injunction issued by the district court should be affirmed.

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