Nos. 23-35440, 23-35450

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

v.

STATE OF IDAHO,
Defendant-Appellant,

v.

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,
Intervenors-Defendants-Appellants.

On Appeal from the United States District Court
for the District of Idaho

BRIEF FOR THE 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, WISCONSIN, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF APPELLEE

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INTRODUCTION AND INTERESTS 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, Wisconsin, and the District of Columbia submit this brief in support of appellee the United States of America.

Amici have a substantial interest in this case. To start, amici own and operate hospitals subject to EMTALA, employ healthcare personnel, oversee hospitals, and license and regulate healthcare providers operating in those hospitals. As regulators, amici have a distinct perspective on the proper interpretation of that statute. Moreover, allowing States to prohibit emergency medical care required by EMTALA would strain the healthcare systems of States that continue to provide such care, including many amici States. In addition, amici have a strong interest in protecting the health of their residents who need emergency care while in Idaho or other States that may wish to depart from EMTALA's mandates.

Since it was first enacted in 1986, EMTALA has been crucial in ensuring that hospital emergency departments provide appropriate medical screening and stabilizing care. The district court correctly concluded that emergency care required by EMTALA includes abortion when a pregnant individual experiencing an emergency medical condition needs an abortion to prevent serious harm to their

health, or to prevent a serious impairment to a bodily function or serious dysfunction of an organ or body part. *See* 42 U.S.C. § 1395dd(e)(1)(A). Idaho law, however, criminalizes abortion in nearly all situations, including when pregnant patients experiencing emergency medical conditions require abortion care to prevent serious health harms. Idaho Code §§ 18-622, 18-604 (authorizing abortion only when "necessary to prevent" patient's "death," remove "an ectopic or molar pregnancy," or where pregnancy resulted from "rape or incest").

Amici submit this brief to explain, based on their experience, that EMTALA requires hospitals to provide emergency abortion care 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 emergency abortion care required by EMTALA is prohibited in Idaho. These harms provide a strong basis to affirm the injunctive relief granted by the district court.

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.[1]

[1] *See* Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians,* 14 Baylor Univ. (continued…)

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 "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). 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 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

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Med. Ctr. Proc. 339, 340 (2001), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/.

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).

As relevant here, stabilizing treatment required by EMTALA may include abortion. 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 receive immediate abortion care.[2] Such medical conditions include where 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

[2] *See Facts Are Important: Abortion Is Healthcare*, Am. College of Obstetricians & Gynecologists ("ACOG"), https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare (last accessed Oct. 9, 2024) (complications "may be so severe that abortion is the only measure to preserve a woman's health or save her life."); *Fact Check—Termination of pregnancy can be necessary to save a woman's life, experts say*, Reuters (Dec. 27, 2021), https://reuters.com/article/idUSL1N2TC0VD/.

seizure, stroke, kidney failure, and other harms (periviable severe preeclampsia).[3] 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 medical benefits of transfer outweigh associated risks to the individual, EMTALA mandates that a patient 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 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 2011, 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

[3] *See, e.g.*, *Preeclampsia and High Blood Pressure During Pregnancy*, ACOG, https://www.acog.org/womens-health/faqs/preeclampsia-and-high-blood-pressure-during-pregnancy (last updated Apr. 2022); *Bleeding During Pregnancy*, ACOG, https://www.acog.org/womens-health/faqs/bleeding-during-pregnancy (last updated May 2021); 1-LEG-ER 20-24 (ECF No. 11-2).

(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.[4] 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.[5] 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 & Hum. Servs.*, 934 F.2d 1362, 1367-76 (5th Cir. 1991) (affirming enforcement action against hospital where pregnant individual presented with severe hypertension).[6]

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[4] *See Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011).

[5] *See* Mem. from Dirs., Quality, Safety & Oversight Grp. & Survey & Operations Grp., CMS, to State Survey Agency Dirs. (Sept. 17, 2021) (as revised regarding enforcement Dec. 3, 2022) https://www.cms.gov/files/document/qso-21-22-hospital.pdf.

[6] *See also* HHS & Dep't of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2019*, at 45 (2020), https://oig.hhs.gov/publications/docs/hcfac/FY2019-hcfac.pdf (describing enforcement action involving pregnant individual with preeclampsia); HHS, Off. Inspector Gen., *Semi-Annual Report to Congress: April 1 – September 30, 2015*, at 37 (2015), https://oig.hhs.gov/reports-and-publications/archives/semiannual/2015/sar-fall15.pdf (same, pregnant individual with abdominal and lower back pain symptoms); HHS, Off. Inspector Gen., *Semi-Annual Report to Congress: April 1, 2007 – September 30, 2007*, at 26 (2007), (continued…)

Most recently, in July 2022, CMS issued guidance reiterating EMTALA's obligations regarding patients who are pregnant or experiencing pregnancy loss.[7] The CMS guidance restates 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 complications. 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.

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https://oig.hhs.gov/publications/docs/semiannual/2007/SemiannualFinal2007.pdf (same, symptoms of vaginal bleeding, cramps, and decreased fetal movement); HHS, Off. Inspector Gen., *Semi-Annual Report to Congress: October 1, 1999 – March 30, 2000*, at 32-33 (2000), https://oig.hhs.gov/publications/docs/semiannual/2000/00ssemi.pdf (same, symptom of sharp abdominal pain).

[7] *See* Mem. from Dirs., Quality, Safety & Oversight Grp. & Survey & Operations Grp., CMS, to State Survey Agency Dirs. (July 11, 2022) (as revised regarding enforcement Aug. 25, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.

Courts throughout the country likewise 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. E. 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 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 clinic where they received care has a transfer agreement in place or the treating physician has admitting privileges at the hospital.[8]

[8] *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 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*, (continued…)

Under the 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.

Appellants argue that EMTALA does not require emergency abortion care. Idaho Replacement Brief (Idaho Br.) 29-32; Legislature Replacement Br. (Legislature Br.) 44-46. 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 United States v. Idaho*, 623 F. Supp. 3d 1096, 1109-10 (D. Idaho 2022); *United States v. Idaho*, No. 1:22-cv-00329-BLW, 2023 U.S. Dist. LEXIS 79235, at *11-12 (D. Idaho 2023) (denying motion for reconsideration).

Instead of grappling with that combined precedent, enforcement history, and federal guidance interpreting EMTALA to require all forms of necessary stabilizing treatment, including abortion care, Appellants focus on certain references in EMTALA to delivery in cases of active labor and to conditions that endanger the

748 F.3d 583 (5th Cir. 2014); *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).

health of a fetus. Idaho Br. 29-31; Legislature Br. 5-6, 44-46. Appellants misunderstand those provisions. Contrary to Appellants' argument, these provisions do not foreclose a requirement of 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 not otherwise 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 not required 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 Appellants contend. *See* Idaho Br. 30-31; Legislature Br. 44-46. Appellants 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.[9] 42 U.S.C. § 1395dd(e)(1)(A)(i). That

[9] 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* 42 U.S.C. § 1395dd(e)(1)(A)(ii)-(iii).

language does not mean that EMTALA forecloses any treatment for a pregnant patient's emergency medical condition that might 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 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. *See Moyle v. United States*, 144 S. Ct. 2015, 2018-19 (2024) (Kagan, J. concurring) (citing legislative history).

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 by leaving to the pregnant individual the choice of whether to pursue stabilizing abortion care or continue the pregnancy. 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 patient.[10]

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. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278-79 (1990); *see also id.* at 342, n.14 (noting that "'no right is held more sacred, or is more

[10] Contrary to Idaho's argument (Idaho Br. 32), the informed consent requirement is important not because it independently requires stabilizing abortion care, but because it recognizes that the individual patient ultimately determines whether to pursue recommended stabilizing treatment.

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. Cal.*, 342 U.S. 165 (1952) (criminal defendant's constitutional right to liberty was violated by obtaining evidence through forced stomach pumping without consent). Second, when EMTALA was enacted in 1986 and shortly thereafter amended to reflect its current structure, the Supreme 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 Reprod. 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.

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

Allowing Idaho to override EMTALA's protections for patients who require health-preserving emergency abortion care will result in multiple harms: (1) pregnant patients denied emergency abortion care will die or suffer irreversible injuries; (2) healthcare providers will leave Idaho, diminishing health system capacity and worsening patient care; and (3) pregnant Idahoans will seek emergency abortion care in amici States, further straining many amici States' already

overwhelmed health systems. These harms quickly materialized during the months that Idaho's abortion ban interfered with the full protections of EMTALA and will undoubtedly return and worsen if this Court reverses the district court's order granting a preliminary injunction.

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 without immediate abortion care.[11] 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.[12] Idaho, however, has recently banned abortion without allowing a sufficient exception for medical emergencies.[13] Idaho's ban deprives

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[11] *See Facts Are Important: Abortion Is Healthcare*, *supra* note 2; *Fact Check—Termination of pregnancy can be necessary to save a woman's life, experts say*, *supra* note 2.

[12] Some hospitals in amici States that do not regularly provide abortions in non-emergency settings explicitly allow abortion when it is the appropriate treatment for an emergency condition and therefore required under EMTALA. *See, e.g.,* Wash. State Dep't Health, *Hospital Reproductive Health Services for Lourdes Hospital* 1 (Sept. 3, 2019), https://doh.wa.gov/sites/default/files/hospital-policies/LourdesRHSF.pdf.

[13] Abortion is banned in thirteen States, and extremely restricted in several more. Ctr. for Reprod. Rts., *After* Roe *Fell: Abortion Laws by State*, https://reproductiverights.org/maps/abortion-laws-by-state (last accessed Oct. 9, 2024). In certain other States, abortion bans and restrictions are enjoined pursuant to ongoing litigation. *Id*. Of States with bans or gestational or viability limits, seven do (continued…)

patients of care covered by EMTALA by: (1) prohibiting providers from offering emergency abortion care by authorizing abortions only in situations narrower than those contemplated by EMTALA; and (2) deterring providers from offering emergency abortion care that may actually be authorized under state law because it is often unclear when a condition will satisfy a ban's exception. The ban denies care in these ways in part because "much of medicine is a gray area" and "most maternal life risks" are not "straightforward."[14] Providers may know the morbidity and mortality rates of particular emergency conditions, but they generally cannot guarantee that a patient will experience a specific outcome, nor discern exactly when a patient's emergency condition moves from health-damaging to life-threatening. As one reproductive health expert 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."[15] Given the

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not provide an express health-preserving exception. Ivette Gomez et al., *Abortions Later in Pregnancy in a Post*-Dobbs *Era* Fig. 5¸ KFF (updated July 23, 2024), https://www.kff.org/womens-health-policy/issue-brief/abortions-later-in-pregnancy-in-a-post-dobbs-era/.

[14] Tina Reed, *Defining "Life-Threatening" Can Be Tricky in Abortion Law Exceptions*, Axios (June 28, 2022), https://www.axios.com/2022/06/28/abortion-ban-exceptions-women-medical-emergencies.

[15] Aria Bendix, *How Life-Threatening Must a Pregnancy Be to End It Legally?*, NBC News (June 30, 2022), https://www.nbcnews.com/health/health-

(continued…)

serious penalties for violating Idaho's law, and the risk that even good-faith medical judgments will be second guessed, ambiguity regarding the legality of emergency abortion care creates a "culture of fear"—deterring providers from performing emergency abortions even when EMTALA requires them.[16]

Denying stabilizing abortion care when a pregnant patient faces a serious health threat can cause severe and irreparable injury, including hysterectomy and fertility loss, kidney failure, brain injury, and limb amputation, forcing the patient to live "with significant disabilities and chronic medical conditions." 1-LEG-ER 14-16, 20-24 & 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

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news/abortion-ban-exceptions-life-threatening-pregnancy-rcna36026; *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), https://nejm.org/doi/full/10.1056/NEJMp2206246#.Yn2CbLw4QWE.

[16] *Impacts of a Post*-Roe *America: The State of Abortion Policy After* Dobbs at 13, U.S. Senate Health, Educ., Labor, & Pensions Comm. (Aug. 1, 2022), https://www.help.senate.gov/imo/media/doc/8.01.2022%20Final%20Post-Dobbs%20Report.pdf; *see also* Kavitha Surana, *Their States Banned Abortion. Doctors Now Say they Can't Give Women Potentially Lifesaving Care.*, ProPublica (Feb. 26, 2024), https://www.propublica.org/article/abortion-doctor-decisions-hospital-committee; Erika L. Sabbath et al., *US Obstetrician-Gynecologists' Perceived Impacts of Post*-Dobbs v Jackson *State Abortion Bans*, JAMA Network Open. (Jan. 17, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814017; Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the Dobbs Ruling*, 328 JAMA 1691 (Nov. 1, 2022).

such as septic emboli [infected blood clots] necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but could still be alive." 1-LEG-ER 22-24 (quoting Corrigan Suppl. Decl. (Dkt. 86-3) ¶ 8). EMTALA requires stabilizing emergency care be offered to avoid such harms. 42 U.S.C. § 1395dd(e)(1)(A)(ii)-(iii).

Delaying stabilizing abortion care until a doctor has "documentation of an unambiguous threat to life is" likewise "dangerous."[17] "[T]he longer emergency abortions are delayed, the greater the risk that lifesaving interventions might not work and pregnant individuals could experience morbidity and mortality."[18] In emergency care generally, "each hour of delayed care increases the patient's likelihood of dying by approximately 4%."[19] That risk may be even higher for pregnant patients, who are often "young and healthy; thus, they are able to compensate for severe physiologic derangements and might not appear ill until very late in their course of critical illness."[20] As an obstetrician-gynecologist in Idaho

[17] MacDonald et al., *supra* note 16; *see also Impacts of a Post*-Roe *America: The State of Abortion Policy After* Dobbs, *supra* note 16 at 13-15; Sabbath et al., *supra* note 16 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), https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html.

[18] MacDonald et al., *supra* note 16.

[19] *Id.*

[20] *Id.*

explained, if providers delay care "until we can say an abortion is necessary to prevent death . . . [p]atients will suffer pain, complications, and could die."[21] A self-described "pro-life" obstetrician-gynecologist in Idaho emphasized, if doctors are forced to wait for an unambiguous threat to life, "there's going to be a certain number of those that you don't pull back from the brink."[22]

These harms are not hypothetical. Women have already experienced serious harms and even died because of delays and denials of emergency abortion care due to abortion bans. A woman had to leave Idaho for emergency pregnancy care and "turned septic in the hours it took her to get to [Utah]."[23] At least two women died in Georgia because they could not receive or were afraid to seek timely abortion care.[24] One woman, Amber Thurman—mother to a six-year-old son—died after a

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[21] Lisa Baumann, *Idaho abortion law one reason hospital won't deliver babies*, AP News (Mar. 23, 2023), https://apnews.com/article/hospital-baby-delivery-idaho-abortion-ban-040fb50e0e069967efcb3fcd72a56677; Goodman & Ghorayshi, *supra* note 17.

[22] Sarah Zhang, *'That's Something That You Won't Recover From as a Doctor'*, Atlantic (Sept. 12, 2024), https://www.theatlantic.com/magazine/archive/2024/10/abortion-ban-idaho-ob-gyn-maternity-care/679567/.

[23] *Id.*

[24] Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable.*, ProPublica (Sept. 16, 2024), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death; Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, ProPublica (Sept. 18, 2024), https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia.

hospital waited 20 hours to provide emergency abortion care because it was unclear whether Georgia's abortion ban allowed the physicians to legally provide the care.[25] The other woman, Candi Miller—mother of three—died after not seeking emergency abortion care "due to the current legislation on pregnancies and abortions."[26] As Georgia's committee of maternal health experts determined, these deaths were avoidable.[27] EMTALA is the backstop that helps to ensure patients like Amber and Candi do not die avoidable deaths.

A recent maternal morbidity study also documented harms of delayed care following Texas's enactment of its abortion ban. The study evaluated pregnant patients who presented at hospitals with certain emergency pregnancy complications and received observation-only care until they developed an immediate threat to their life, their fetus expired, or they went into labor. The rate of serious maternal morbidity for these patients (57%) was nearly double that of patients with similar complications in other States who were able to immediately terminate their pregnancies (33%).[28] The Texas patients endured hysterectomy, hemorrhage, severe

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[25] Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable.*, *supra* note 24.

[26] Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, *supra* note 24.

[27] *Id.*

[28] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas*
(continued…)

infection, intensive care admission, and hospital readmission, among other harms. Forcing these patients to suffer such harms did not correspond to improved perinatal outcomes—all but one patient in the study lost their fetus or infant, with the majority dying during labor or within 24 hours of delivery.[29]

Patients are also harmed by having to travel for emergency abortions. When the preliminary injunction was stayed, numerous pregnant patients were airlifted out of Idaho for emergency pregnancy complication care.[30] Those patients must endure the risks of delayed care—exacerbated complications, more extensive treatment, a higher likelihood of emergency follow-up care, and costs to their emotional and mental health—and absorb related out-of-pocket expenses.[31] A pregnant Idahoan

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Hospitals After Legislation on Abortion, 227 Am. J. Obstetrics & Gynecology 648, 648-50 (2022), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2900536-1.

[29] *Id.* at 649.

[30] Bracey Harris, *Why Idaho's hospitals are having pregnant patients airlifted out of state*, NBC News (Apr. 25, 2024), https://www.nbcnews.com/news/us-news/idahos-abortion-emergency-supreme-court-airlifted-rcna148828.

[31] *See* Allison McCann, *As Abortion Access Shrinks, Hospitals Fill in the Gaps*, N.Y. Times (Oct. 23, 2023), https://www.nytimes.com/interactive/2023/10/23/us/abortion-hospitals.html; 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), https://www.businessinsider.com/personal-finance/high-risk-low-income-patients-abortion-more-expensive-2023-10; Katrina Kimport & Maryani Palupy Rasidjan, *Exploring the emotional costs of abortion travel in the United States due to legal restriction*, 120 Contraception 109956 (Apr. 2023), https://contraceptionjournal.org/article/S0010-7824(23)00009-4/fulltext.

whose water broke early was transported to Oregon for care she could not get in Idaho, forcing her to deliver her fetus (which did not survive) hundreds of miles from home and leaving her to figure out how to get back to Idaho alone following the one-way medical transport.[32] Yet the alternative—remaining in Idaho without any access to emergency abortion care—is so untenable that some Idaho providers have been advising pregnant patients to purchase memberships with private air transport companies.[33]

Regrettably, too many patients have already suffered because Idaho forced providers to deny or delay medically-indicated emergency abortions.[34] Prohibiting providers from offering medically-necessary, evidence-based emergency abortion

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[32] Zhang, *supra* note 22.

[33] Kelcie Moseley-Morris, *Loss of federal protection in Idaho spurs pregnant patients to plan for emergency air transport*, Id. Capital Sun (Apr. 23, 2024), https://idahocapitalsun.com/2024/04/23/loss-of-federal-protection-in-idaho-spurs-pregnant-patients-to-plan-for-emergency-air-transport/. Specialty care teams must accompany patients in case of complications, which means those providers are "tied up for many hours and therefore unavailable to other hospital patients who may need them." *Id.*

[34] *See, e.g.*, Sabbath et al., *supra* note 16; Daniel Grossman et al., *Care Post-Roe: Documenting cases of poor-quality care since the* Dobbs *decision*, Advancing New Standards in Reproductive Health (ANSIRH) 7, U.C.S.F. (Sept. 2024), https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf; Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion.*, ProPublica (Mar. 14, 2023), https://propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy (identifying "at least 70 examples across 12 states of women with pregnancy complications who were denied abortion care or had the treatment delayed since [*Dobbs*]").

care to pregnant patients threatens patients' lives and well-being—precisely the sort of harms that Congress created EMTALA to avoid. *See* 1-LEG-ER 17-18.

B. Prohibiting Emergency Abortion Care Harms Healthcare Systems and Overall Patient Care in Idaho

Idaho's abortion ban broadly undermines healthcare delivery and patient outcomes by driving healthcare providers out of Idaho. This provider exodus harms Idaho residents and threatens residents of amici States who require healthcare while living in or visiting Idaho. These harms will be exacerbated if Idaho is allowed to override EMTALA's emergency care requirements.

Within just a few months of going into effect, Idaho's abortion ban had already pushed nearly one in four obstetricians to leave the State or retire.[35] This includes over half of Idaho's maternal-fetal-medicine specialists, who treat complex and high-risk pregnancies most likely to need emergency care, leaving just four such specialists in Idaho as of 2023.[36]

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[35] *A Post Roe Idaho*, Idaho Physician Well-Being Action Collaborative & Idaho Coalition for Safe Healthcare 2 (Feb. 2024), https://www.idahocsh.org/idaho-physician-wellbeing-action-collaborative.

[36] Sheryl Gay Stolberg, *As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers*, N.Y. Times (Sept. 6, 2023), https://nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html; Randi Kaye & Stephen Samaniego, *Idaho's murky abortion law is driving doctors out of the state*, CNN (May 13, 2023), https://www.cnn.com/2023/05/13/us/idaho-abortion-doctors-drain/index.html; Kathleen McLaughlin, *No OB-GYNs Left in Town: What Came After Idaho's Assault on Abortion*, Guardian (Aug. 22, 2023), https://www.theguardian.com/us- (continued…)

This exodus harms Idaho hospitals.[37] At least three Idaho hospitals have stopped providing obstetrical services because of the ban, with one explaining that because Idaho criminalizes physicians for providing medically-necessary care, "[h]ighly respected, talented physicians are leaving. Recruiting replacements will be extraordinarily difficult."[38] And providers have reported that whether they are allowed to provide health-preserving emergency abortion care—rather than just life-preserving—impacts whether they will work in Idaho.[39] A 2023 survey of Idaho physicians found that while 64% of physicians surveyed were considering leaving Idaho because of the abortion ban, 96% of obstetrician-gynecologists considering leaving Idaho would "consider staying" or "very likely stay" if there was a health exception.[40]

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news/2023/aug/22/abortion-idaho-women-rights-healthcare; Christopher Rowland, *A Challenge for Antiabortion States: Doctors Reluctant to Work There*, Wash. Post (Aug. 6, 2022), https://wapo.st/3w1ujfC.

[37] *See, e.g.*, Amanda Sullender, *Idahoans in rural Sandpoint reflect on a year without labor and delivery services*, Spokesman-Review (Mar. 11, 2024), https://www.spokesman.com/stories/2024/mar/11/amid-pro-abortion-protest-idahoans-in-rural-sandpo/.

[38] Kyle Pfannenstiel, *Idaho is losing OB-GYNs after strict abortion ban. But health exceptions unlikely this year*, Id. Capital Sun (Apr. 5, 2024), https://idahocapitalsun.com/2024/04/05/idaho-is-losing-ob-gyns-after-strict-abortion-ban-but-health-exceptions-unlikely-this-year/.

[39] *Id.*

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

(continued…)

When hospitals close or reduce their capacity to provide obstetric and gynecologic care, patients suffer, exacerbating the need for emergency care. They lose ready access to critical healthcare services, including gynecologic surgery, gynecologic oncology care, and infertility treatment.[41] Pregnant patients must travel further for prenatal and labor and delivery care, often at greater logistical and financial cost.[42] When prenatal care is more difficult to access, rates of serious complications—including preterm birth and maternal and fetal mortality—increase.[43]

Patients likewise suffer when they lose ready access to family practitioners, who deliver a "range of preventative and urgent care services needed to sustain a healthy community."[44] Fourteen family practitioners planned to leave Idaho by the

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https://static1.squarespace.com/static/630d454b97367a04219ef01f/t/653ff99f37bbbb6cf9f396f5/1698691487342/ICSRHC+Survey+Report+May+2023.pdf.

[41] *See Subspecialties of OB-GYN*, ACOG (2023), https://www.acog.org/career-support/medical-students/medical-student-toolkit/subspecialties-of-ob-gyn.

[42] 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://www.nbcnews.com/health/womens-health/pregnant-women-struggle-find-care-idaho-abortion-ban-rcna117872.

[43] *Id.*; March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S., 2024 Report* (2024), https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf; U.S. Dep't Health & Hum. Servs., Office on Women's Health, *Prenatal Care* (last updated Feb. 22, 2021), https://womenshealth.gov/a-z-topics/prenatal-care.

[44] *Idaho Physician Retention Survey—May 2023, supra* note 40 at 4.

end of 2023 because of the abortion ban, including twelve practicing in rural areas, where they were the "foundation" on which "patients depend to access health and life preserving care."[45]

According to the chief physician executive for St. Luke's Health System in Boise, because of Idaho's abortion ban, Idaho's entire care system is beginning to collapse: "If the momentum doesn't shift . . . there's no question that there will be bad perinatal outcomes for moms and babies."[46]

C. Prohibiting Emergency Abortion Care Harms Amici States

Allowing Idaho to eviscerate EMTALA's nationwide guarantee of stabilizing emergency care will drive even more pregnant patients to amici States for emergency health-preserving abortions. That influx may result in more crowded waiting rooms, increased delays for urgent healthcare, and overall strains on many amici's healthcare systems.

State abortion restrictions have already forced many pregnant individuals to travel out of state. In the four months following implementation of Texas's six-week abortion ban, the number of Texans seeking abortions in nearby States increased by

[45] *Id.*

[46] Kaye & Samaniego, *supra* note 36.

984%.[47] 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.[48] In Illinois, the number of out-of-state abortion patients grew by 49%.[49] Colorado's share of out-of-state abortion patients doubled.[50] In California, clinics across the state saw skyrocketing increases in out-of-state patients seeking abortions, with some clinics seeing four-fold, 500%, and 900% increases.[51] These trends have

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[47] Kari White et al., Tex. Pol'y Evaluation Project, *Out-of-State Travel for Abortion Following Implementation of Texas Senate Bill 8* 1 (Mar. 2022), https://sites.utexas.edu/txpep/files/2022/03/TxPEP-out-of-state-SB8.pdf.

[48] Lauren Gallup & Rachel Sun, *Number of Idaho abortion patients traveling to Washington up 56% after Roe overturned*, OPB (July 10, 2023), https://www.opb.org/article/2023/07/10/idaho-abortion-patients-traveling-to-washington-increases-56-percent-after-roe-overturned/.

[49] Angie Leventis Lourgos, *Illinois abortions surged the year* Roe *fell, with nearly 17,000 patients traveling from other states*, Chic. Trib. (Jan. 11, 2024), https://www.chicagotribune.com/2024/01/10/illinois-abortions-surged-the-year-roe-fell-with-nearly-17000-patients-traveling-from-other-states-a-49-spike/.

[50] John Daley, *Abortion numbers rise sharply in Colorado, driven by out-of-state patients*, Colo. Pub. Radio News (Sept. 11, 2023), https://www.cpr.org/2023/09/11/abortion-numbers-rise-sharply-in-colorado-driven-by-out-of-state-patients/ (reporting 60 times more patients from Texas seeking abortions in 2022 than 2019).

[51] Marisa Kendall, *Demand has quadrupled at some California abortion clinics since Roe fell*, Mercury News (Jan. 1, 2023), https://www.mercurynews.com/2023/01/01/demand-has-tripled-quadrupled-at-california-abortion-clinics-since-roe-fell/; Karma Dickerson, *More out-of-state patients begin arriving in California for reproductive health services*, Fox 40 News (Sept. 20, 2022), https://fox40.com/news/fox40-focus/out-of-state-patients-reproductive-health-abortion-california/; Cindy Carcamo, *A California desert town has long been an abortion refuge for Arizona and Mexico. Now it's overwhelmed*,

(continued…)

continued at the two-year mark post-*Dobbs*, with many other amici States experiencing similarly drastic increases in out-of-state patients seeking abortion care.[52] Indeed, nationally, during the first six months of 2023, nearly one in five patients crossed state lines to obtain abortion care—more than double the number during the same period in 2020.[53]

Some of these out-of-state patients required emergency abortions to preserve their health. For example, when a physician was forced by Tennessee's ban to deny abortion care to a pregnant patient at risk of severe preeclampsia—"a serious health emergency" but not one the physician was confident would be deemed life-threatening—the patient had to travel six hours by ambulance to North Carolina for care.[54] The patient arrived in North Carolina "with dangerously high blood pressure

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L.A. Times (July 20, 2022), https://www.latimes.com/california/story/2022-07-20/planned-parenthood-clinic-in-this-conservative-desert-town-is-now-a-refuge-for-arizonans-seeking-abortions.

[52] *See, e.g.*, *#WeCount Public Report: April 2022 to September 2023*, Soc'y of Family Planning (Feb. 28, 2024), https://societyfp.org/wp-content/uploads/2024/02/SFPWeCountPublicReport_2.28.24.pdf.

[53] Kimya Forouzan et al., *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Inst. (Dec. 2023), https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care.

[54] Laura Kusisto, *Doctors Struggle with Navigating Abortion Bans in Medical Emergencies*, Wall Street J. (Oct. 13, 2022), https://www.wsj.com/articles/doctors-struggle-with-navigating-abortion-bans-in-medical-emergencies-11665684225?mod=politics_lead_pos9.

and signs of kidney failure," requiring more critical care than if she had received care in Tennessee.[55] A 19-week-pregnant Texas patient's water broke—putting her at risk of septic shock and hemorrhage—but her providers were afraid to treat her until her health deteriorated to imminent risk of death.[56] Rather than jeopardize her health, she flew to Colorado for an emergency abortion.[57] Likewise, a pregnant Idahoan with serious kidney disease urgently needed but was denied a health-preserving abortion, forcing her to leave her family and fly several hours away for care.[58] These are not isolated incidents—Oregon Health & Science University providers report seeing these types of cases weekly.[59]

Forcing patients to travel for out-of-state emergency abortions harms amici and other States to which they travel. Hospital emergency rooms in many amici States already struggle with overcrowding, long wait times, and staff shortages,

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[55] *Id.*

[56] Eleanor Klibanoff, *Women denied abortions sue Texas to clarify exceptions to the law*, Tex. Tribune (Mar. 7, 2023), https://www.texastribune.org/2023/03/07/texas-abortion-lawsuit/.

[57] *Id.*

[58] Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Tribune (May 2, 2023), https://www.sltrib.com/news/nation-world/2023/05/02/after-idahos-strict-abortion-ban/.

[59] Nicole Rideout, *One year since the overturn of Roe, OB/GYNs report devastating impacts from lack of abortion access*, OSHU News (June 24, 2023), https://news.ohsu.edu/2023/06/24/one-year-since-the-overturn-of-roe-obgyns-report-devastating-impacts-from-lack-of-abortion-access.

particularly in rural and underserved areas, all of which can impact patient morbidity and mortality.[60] An influx of out-of-state patients requiring critical abortion care aggravates existing stresses on these overburdened healthcare systems, threatening worse health outcomes for all people seeking emergency medical care. It has also led to delays for in-state patients seeking non-emergency abortion care, which in turn lead to a need for more invasive and costly procedures later in pregnancy.[61] The

[60] *See* WRGB Staff, *New York Ranks Fourth in Longest ER Wait Times, New Study Reveals*, CBS 6 News (Aug. 21, 2023), https://cbs6albany.com/news/local/new-york-ranks-fourth-in-longest-er-wait-times-new-study-reveals-emergency-room-hospital-treatment-in-new-york-state (eight amici States are among top ten 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), https://patientengagementhit.com/news/emergency-department-ed-overcrowding-leads-to-worse-health-outcomes (overcrowding can lead to 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), https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217 ("The impact of [emergency department] overcrowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented.").

[61] *See* Matt Bloom & Bente Berkland, *Wait Times at Colorado Clinics Hit Two Weeks as Out-of-State Patients Strain System*, KSUT (July 28, 2022), https://www.ksut.org/health-science/2022-07-28/wait-times-at-colorado-abortion-clinics-hit-2-weeks-as-out-of-state-patients-strain-system (reporting 100% increase in abortion wait times in Colorado clinics since *Dobbs*); Marielle Kirstein et al., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care*, Guttmacher Inst. (Oct. 6, 2022), https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care ("dramatic" caseload increases are stretching clinic capacity and staff to their limits and increasing care wait times).

injunctive relief granted by the district court is critical to protect patient health and preserve healthcare systems, both in Idaho and amici States.

CONCLUSION

This Court should affirm the district court's order enjoining enforcement of Idaho's abortion ban to the extent it conflicts with EMTALA.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,858 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft in Times New Roman 14-point font, a proportionally spaced typeface.

Dated: October 22, 2024

/s/ Hayley Penan
Hayley Penan

CERTIFICATE OF SERVICE

I certify that on October 22, 2024, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that services will be accomplished by the appellate EM/EC system.

Dated: October 22, 2024

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