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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329-BLW **REPLY MEMORANDUM IN SUPPORT OF MOTION FOR A PRELIMINARY INJUNCTION**

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INTRODUCTION

The conflict between Idaho's abortion ban and EMTALA is clear from the plain language of the Idaho law and the testimony from multiple local physicians explaining how Idaho's law will prevent critical medical care for pregnant patients in emergency conditions. Idaho could have designed a law allowing patients with emergency conditions to obtain necessary care. Instead, the State enacted a law that permits the prosecution of any physician who performs any abortion, even as a life-saving treatment. The State focuses on the law's affirmative defense, which can be raised only at trial, and only then if abortion is "necessary" to prevent death. But even where the affirmative defense seemingly applies, it does not eliminate the risk for physicians or their patients. And the scope of the affirmative defense is insufficient when compared to EMTALA's requirements. Without an injunction against § 18-622's enforcement, physicians will be faced with an untenable choice and pregnant patients in Idaho will be put in danger.

There is no dispute that EMTALA's requirement to offer "stabilizing treatment" applies to pregnant patients, nor is there any dispute that some pregnant patients will present at a hospital with an emergency medical condition for which pregnancy termination is the necessary stabilizing treatment. Both the State of Idaho and the Idaho Legislature have filed briefs and submitted declarations expressly acknowledging that EMTALA requires hospitals to offer termination of the pregnancy as potential stabilizing treatment under relevant circumstances.

Instead, Defendants argue that § 18-622 does not actually conflict with EMTALA's requirements. But Defendants' factual submissions—about how they understand the term "abortion" and how they believe doctors should decide when to perform an emergency abortion—cannot be reconciled with the Idaho law's statutory text, which criminalizes all abortions (no matter how medically necessary or life-saving), and allows medical professionals to avoid criminal liability only by proving an affirmative defense that is narrower than what EMTALA requires. Under well-settled

preemption principles, § 18-622 conflicts directly with EMTALA. And based on the significant irreparable harm that would be caused if § 18-622 were allowed to go into effect, particularly for pregnant individuals in Idaho and the United States' sovereign interests, the United States is entitled to a preliminary injunction against § 18-622's enforcement, as applied to EMTALA-mandated care.

ARGUMENT

I. The United States Has Authority to Bring this Suit and Seek Injunctive Relief

Before turning to the preemption issues at the heart of this case, the State obliquely raises several threshold issues regarding the United States' authority to bring this suit. None has merit, and the standard for facial challenges is likewise no impediment to entering relief here.

A. The United States Has Standing and a Cause of Action

The State of Idaho alludes to "questions . . . that eventually may require resolution" regarding the United States' standing and cause of action for this suit, Idaho Br. at 7-8, but then expressly disclaims seeking a ruling on those arguments for purposes of this motion. Regardless, the State's arguments are meritless. It is "beyond doubt" that the United States suffers an "injury to its sovereignty arising from violation of its laws," *Vt. Agency of Nat. Res. v. U.S. ex rel Stevens*, 529 U.S. 765, 771 (2000), which is precisely what is alleged in this case with respect to § 18-622. And the Ninth Circuit has held that the United States has standing when a state or local law "proscribe[s] some activity encouraged by federal law." *United States v. City of Arcata*, 629 F.3d 986, 989 (9th Cir. 2010); *see also United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011) (holding, in the context of a Supremacy Clause claim, that "an alleged constitutional infringement will often alone constitute irreparable harm"), *rev'd in part on other grounds*, 567 U.S. 387 (2012). Section 18-622 interferes with Congressional policy as reflected in EMTALA, and the United States may sue to enforce those Federal interests. *See Wyandotte Transp. Co. v. United States*, 389 U.S. 191, 201 (1967) ("Our decisions have established, too, the general rule that the United States may sue to protect its interests."); *United States v. Alabama*, 691

F.3d 1269, 1301 (11th Cir. 2012); *United States v. Arlington Cnty.*, 326 F.2d 929, 931-32 (4th Cir. 1964).

Moreover, if § 18-622 is allowed to go fully into effect, it will have widespread public health consequences for countless pregnant patients within Idaho. *See* US Br., Dkt. 17-1 at 17-19; *see also* Dkt. 59 at 15-17 (discussing interstate harms). The Supreme Court long ago recognized the United States' authority to sue to redress injuries to the general welfare: "Every government, intrusted by the very terms of its being with powers and duties to be exercised and discharged for the general welfare, has a right to apply to its own courts for any proper assistance in the exercise of the one and the discharge of the other[.]" *In re Debs*, 158 U.S. 564, 584 (1895). That is not a matter of third-party standing, *see* Idaho Br. at 7-8, but rather the United States asserting its own interest in preventing widespread public harm.

Idaho's law also deprives the United States of the benefit of its bargain in connection with Medicare funding provided to hospitals within Idaho. That funding was expressly conditioned on Idaho-based hospitals' compliance with EMTALA, *see* 42 U.S.C. § 1395cc(a)(1)(I)(i), and Idaho law now prohibits such compliance. Thus, § 18-622 harms "the administration and integrity of Medicare," *United States v. Mackby*, 339 F.3d 1013, 1018 (9th Cir. 2003), which the State agrees is a cognizable injury. *See* Idaho Br. at 8. The State contends that there are no State-operated hospitals with an emergency department participating in Medicare, *see id.*, but the terms of Spending Clause legislation are enforceable against state laws that interfere with recipients' obligations. *See Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256 (1985) (holding that state law is preempted to the extent it interferes with third parties' compliance with conditions attached to federal funds); *cf. United States v. Marion Cnty. Sch. Dist.*, 625 F.2d 607, 609 (5th Cir. 1980) (recognizing that "the United States has an inherent right to sue for enforcement of the recipient's obligation in court"); *United States v. Mattson*, 600 F.2d 1295, 1299 n.6 (9th Cir. 1979). In any event, there are fifteen *county*-owned hospitals participating in Medicare that *do* have emergency departments. *See* Wright Decl., Dkt. 17-9 ¶ 9. Thus,

the United States can sue to enforce the benefit of its bargain under Medicare.

In terms of a cause of action, the State expresses uncertainty based on *Armstrong v. Exceptional Child Ctr. Inc.*, 575 U.S. 320 (2015), *see* Idaho Br. at 7, but *Armstrong* confirms the United States' cause of action here: there is an equitable cause of action allowing suit "to enjoin unconstitutional actions by state and federal officers," which is a "creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England." 575 U.S. at 327. Nothing more is needed, as confirmed by the numerous recent lawsuits brought by the United States challenging state laws under the Supremacy Clause, none of which was dismissed for lack of a cause of action.[1]

Finally, the State suggests that EMTALA's "detailed remedial scheme" precludes a cause of action. But EMTALA does not contain a process for prospective enforcement against states that criminalize care required by federal law. Rather, the enforcement regime is after-the-fact, and pertains only to physicians and hospitals who have committed "negligent[]" or "gross and flagrant" violations of EMTALA's requirements. 42 U.S.C. § 1395dd(d)(1)(A), (B). Even where it does apply, nothing in EMTALA suggests that its enforcement scheme was intended to *circumscribe* the inherent authority of the United States to enforce its rights in equity. *See United States v. United Mine Workers of Am.*, 330 U.S. 258, 270-71 (1947) (even when statute limits remedies, that generally does not apply to the United States based on the "old and well-known rule that statutes which in general terms divest pre-existing rights or privileges will not be applied to the sovereign without express words to that effect").

B. This Case Is Not a Facial Challenge, and As-Applied Relief Is Appropriate

Idaho also attempts to portray the United States' preemption claim as a "facial challenge" to § 18-622, suggesting that the United States cannot meet that standard for relief. Idaho Br. at 10 (citing

[1] *See, e.g.*, *United States v. Washington*, 142 S. Ct. 1976 (2022); *Arizona*, 567 U.S. at 387; *City of Arcata*, 629 F.3d at 989; *United States v. Supreme Ct. of N.M.*, 839 F.3d 888, 899 (10th Cir. 2016); *Alabama*, 691 F.3d at 1301; *United States v. Colo. Supreme Ct.*, 87 F.3d 1161, 1165 (10th Cir. 1996); *United States v. South Carolina,* 840 F. Supp. 2d 898, 908 (D.S.C. 2011), *aff'd*, 720 F.3d 518 (4th Cir. 2013); *United States v. Texas*, 557 F. Supp. 3d 810, 820 (W.D. Tex. 2021).

Puente Arizona v. Arpaio, 821 F.3d 1098 (9th Cir. 2016), and *John Doe No. 1 v. Reed*, 561 U.S. 186 (2010)). But the United States is not asking this Court "to enjoin enforcement of all applications" of § 18-622 or "strike down the law[] in [its] entirety," "in all contexts as applied to all parties." *Puente Arizona*, 821 F.3d at 1105, 1108. To the contrary, the United States is seeking an injunction against the enforcement of § 18-622 only as applied to EMTALA-mandated care. *Cf.* Compl., Prayer for Relief. Moreover, the United States is not seeking relief "beyond the particular circumstances of these plaintiffs." *John Doe*, 561 U.S. at 194. Instead, the United States is seeking relief necessary to redress its *own* injuries— *i.e.*, relief to protect against the public harms caused by the inconsistency of § 18-622 and federal law.

In any event, even if the standard for facial challenges applied, the State offers no reason why the United States would be unable to meet it here with respect to the class of conduct at issue: EMTALA-mandated care. *See Arizona*, 641 F.3d at 345-46 (holding that the *Salerno* "formulation misses the point: there can be no constitutional application of a statute that, on its face, conflicts with Congressional intent and therefore is preempted by the Supremacy Clause"). Indeed, the Ninth Circuit has had no trouble applying typical (non-*Salerno*) preemption principles where, as here, the plaintiff attacks a statute as applied to a subset of conduct or individuals. *See, e.g.*, *Nat'l R.R. Passenger Corp. v. Su*, 41 F.4th 1147, 1153 (9th Cir. 2022) ("As applied to [plaintiffs'] railroad employees, the [California] Act falls within RUIA's preemption clause."). Under typical preemption principles, Idaho cannot prohibit through § 18-622 medical care that is required to be provided under EMTALA, and § 18-622 is invalid in all of its applications as applied to that swath of conduct.

II. The United States Has Established a Likelihood of Success on Its Preemption Claim

Neither the State nor the Legislature meaningfully disputes that, as a legal matter, EMTALA sometimes requires abortion as a stabilizing treatment. The only question is whether Idaho law stands in the way of that federally mandated medical care. It plainly does. Under § 18-622, all abortions in Idaho expose physicians to criminal prosecution—even when provided in life-threatening situations.

Defendants nowhere grapple with the fact that subjecting medical providers to criminal prosecution for care that is required under federal law creates a direct conflict with that federal law. And while Defendants emphasize the law's affirmative defense—which does not eliminate this fatal flaw—even that affirmative defense is, by its plain text, narrower than EMTALA.

A. There Is No Meaningful Dispute That, As A Legal Matter, EMTALA Sometimes Requires Abortions as Stabilizing Treatments

Both the State and the Legislature expressly acknowledge that EMTALA sometimes requires a physician to offer an abortion when it is the stabilizing treatment for an emergency medical condition. *See* Idaho Br. at 12-13 ("the United States merely identifies circumstances when stabilizing treatment necessitated by EMTALA includes an abortion"); Legisl. Br. at 10 ("'[I]n the emergency situations . . . anticipated by EMTALA, the subordination of the mother's life and health in favor of the unborn child by a physician has not and will not occur.'" (quoting French Decl., Dkt. 71-5 ¶ 9)); *see* US Br. at 8-14. Thus, there is no meaningful dispute here about what federal law requires.

Despite Defendants' (and their declarants') acknowledgment of what EMTALA requires, they refer without elaboration to "legal arguments" suggesting the United States' interpretation is incorrect. Legisl. Br. at 13; Idaho Br. at 19 n.10. These undeveloped arguments have been waived, *see Indep. Towers v. Washington*, 350 F.3d 925, 929-30 (9th Cir. 2003), and in any event are meritless.

First, the "major questions doctrine" is not implicated here because EMTALA is a requirement for emergency care that Congress itself imposed, over 35 years ago, on hospitals receiving federal funds. The major questions doctrine applies "in certain extraordinary cases" when there is an affirmative *agency* regulatory action involving "major policy decisions." *West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (2022) (describing "the major questions doctrine" as arising only in "extraordinary cases" involving "*agencies* asserting highly consequential power beyond what Congress could reasonably be understood to have granted" (emphasis added)). This case involves no assertion of agency authority, and instead the United States is enforcing a "policy decision[]" made by "Congress . . . itself[.]" *Id.*

Second, EMTALA does not violate the Spending Clause. Congress is free to attach conditions to federal funds, *see South Dakota v. Dole*, 483 U.S. 203 (1987), and there is nothing impermissibly coercive about this arrangement because "[o]nly hospitals that voluntarily participate in the federal government's Medicare program must comply with EMTALA." *Burditt v. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991). A decision to participate in Medicare by an individual provider—the vast majority of which are private entities, for whom the "coercion" doctrine does not apply, *see Northport Health Servs. of Arkansas, LLC v. Dep't of Health & Hum. Servs.*, 438 F. Supp. 3d 956, 970–71 (W.D. Ark. 2020)—is fundamentally different from a State's participation in Medicaid, distinguishing this case from *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012); *see also Jones v. Wake Cnty. Hosp. Sys., Inc.*, 786 F. Supp. 538, 547 (E.D.N.C. 1991) (upholding EMTALA under the Spending Clause). And Congress's decision to condition Medicare participation on compliance with EMTALA is no different than numerous other longstanding conditions. *Cf. Biden v. Missouri*, 142 S. Ct. 647, 650-51 (2022). In sum, there is no meaningful dispute about what federal law validly requires—under EMTALA, when patients present to emergency departments with emergency medical conditions, covered hospitals must sometimes offer abortion as a stabilizing treatment.

B. Idaho's "Total Abortion Ban" Prohibits Care that EMTALA Requires

The Supreme Court of Idaho has described § 18-622 as a "Total Abortion Ban." *Planned Parenthood Great Nw. v. Idaho*, --- P.3d ---, 2022 WL 3335696, at *1 (Idaho Aug. 12, 2022). In attempting to argue that there is no direct conflict between a federal law that requires abortion care and Idaho's law criminalizing such care, both Idaho and the Legislature fail to recognize that § 18-622 contains *no* textual exception to its "crime of criminal abortion," for example, in medically necessary situations. That means that a prosecutor who indicts a physician for "criminal abortion" need not make any showing about medical necessity in order to support a felony conviction. The State equates the law's *affirmative defense* with an *exception* to the law's criminal prohibition, but these concepts are markedly

different. Under the Idaho law, any physician who provides any abortion is subject to disciplinary proceedings, criminal prosecution, and a burden of proof. That would not be the case under a law containing an exception from the prohibition itself. The State knows how to write a law allowing exceptions for some abortions but chose not to employ that structure here. *See* Idaho Code § 18-8804(1) (prohibiting certain abortions "except in the case of a medical emergency"); *id.* § 18-505 (similar); *id.* § 18-604(9) (defining "medical emergency"). Because Idaho's Total Abortion Ban contains no exceptions, EMTALA and § 18-622 directly conflict, and Defendants' attempt to rewrite the statute through litigation filings and factual declarations should be rejected.

Importantly, neither the State nor the Legislature disputes that, to the extent § 18-622 imposes criminal liability on conduct that federal law requires, § 18-622 is preempted. *See* US Br. at 15. Instead, both Defendants try to avoid that result by misconstruing Idaho law—suggesting that Idaho's criminal prohibitions do not apply to life-saving care, and implying that the affirmative defense is co-extensive with EMTALA's requirements. These arguments are incorrect both legally and factually.

1. Idaho's Abortion Prohibitions Apply Even to Life-Saving Care

The Legislature (but not the State) argues that life-saving care is not considered an "abortion" under Idaho law, and therefore such care falls outside Idaho's criminal prohibitions. The Legislature presses this argument primarily for ectopic pregnancies, *see* Legisl. Br. at 6-7, but its declarants contend that life-saving care is *never* considered an abortion. *See* French Decl. ¶ 14; Reynolds Decl. ¶ 12.

To be clear, the United States agrees that treatments for ectopic pregnancy and other life-saving care are not considered "abortion" *in the medical community*. *See* US Br. at 7 n.1; Fleisher Decl., Dkt. 17-3 ¶ 3. What is material to this case, however, is how *Idaho law* defines "abortion" in the relevant statutes: "'Abortion' means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child[.]" Idaho Code § 18-604(1). Neither the Legislature

nor its declarants ever address this statutory text, which contains no exceptions for pregnancy terminations necessary to save someone's life or where the pregnancy is nonviable. Regardless of what the medical community considers to be an abortion, therefore, the text of Idaho's abortion laws clearly extends to life-saving pregnancy terminations. *See Worley Highway Dist. v. Kootenai Cnty.*, 576 P.2d 206, 209 (Idaho 1978) ("This Court has consistently adhered to the primary canon of statutory construction that where the language of the statute is unambiguous, the clear expressed intent of the legislature must be given effect and there is no occasion for construction.").

Indeed, with respect to ectopic pregnancies specifically, there can be no doubt that they are included within the statutory definition of "abortion," given that Idaho law expressly defines "pregnancy" to mean "the reproductive condition of having a developing fetus *in the body* and commences with fertilization." Idaho Code § 18-604(11) (emphasis added). The statutory references to "the body" rather than "the uterus," and "fertilization" rather than "implantation," indicate that ectopic pregnancies are included. And the Legislature knows how to exclude an ectopic pregnancy when it wants to. *Id.* § 18-617(1)(a). Again, the Legislature has no answer to this statutory text.

The Legislature's only textual argument on this issue refers to § 18-622(4), which provides: "Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section." *See* Legisl. Br. at 6-7 (contending that this provision "specifies the health of the woman is of primary importance"); French Decl. ¶¶ 15, 21. But this provision explicitly addresses only *accidental* or *unintentional* harm to a fetus; it does not address terminating a pregnancy for life-saving reasons, which even the Legislature's physicians agree is both medically necessary and will *intentionally* end the pregnancy. *See* Reynolds Decl. ¶ 14; French Decl. ¶ 17; White Decl. ¶ 3. This provision cannot be construed as a catch-all for life-saving care, particularly given the statute's more specific provision governing treatment to prevent death. *See* Idaho Code § 18-622(3)(a)(ii); *Valiant*

Idaho, LLC v. JV LLC, 429 P.3d 168, 177 (Idaho 2018) (noting the "basic tenet" that "the more specific statute or section addressing the issue controls over the statute that is more general").[2] Thus, § 18-622's text confirms that it extends to every termination of a pregnancy, regardless of whether the abortion is a life-saving one or whether the procedure would typically be considered an "abortion" within the medical community. The Legislature cannot avoid preemption by re-writing its laws in a legal brief to exclude certain actions from the criminal prohibitions. *See Verska v. Saint Alphonsus Reg'l Med. Ctr.*, 265 P.3d 502, 508 (Idaho 2011) ("We must follow the law as written. If it is socially or economically unsound, the power to correct it is legislative, not judicial.").

Finally, Idaho's theory about how its law works in practice is belied by the actual experience of medical professionals in Idaho who regularly treat women in these situations: emergency care normally provided to pregnant patients is proscribed by § 18-622, which will hinder their ability to provide that care if the law goes into effect. *See* Corrigan Decl. ¶¶ 31-35; Cooper Decl. ¶12; Seyb Decl. ¶ 13. Tellingly, Defendants nowhere grapple with these practical realities. They merely point to declarants who state—without basis or support, and without regard for the plain text of Idaho's law—that no reasonable physician should fear prosecution in Idaho for performing emergency abortions.

2. The Idaho Law's Affirmative Defense Is Narrower than EMTALA Because It Applies Only When Necessary to Prevent Death

The United States' opening memorandum and declarations demonstrated that there are numerous emergency medical conditions under EMTALA for which a doctor might conclude that the necessary stabilizing treatment is termination of the pregnancy, but where termination would not

[2] Dr. French asserts that life-saving terminations of pregnancy cause only "unintentional" harm to the unborn child, because "the intent of the procedure is to save the life of the mother; it is an unintended consequence of the procedure that the baby dies." French Decl. ¶ 14. As this Court previously recognized, however, the scope of § 18-622 is a legal question, not a factual issue for which Dr. French's testimony is relevant. *See* Dkt. 73 at 3. And as a legal matter, Idaho criminal law generally does not require that a person specifically intend the consequences of their actions, only that they have "a purpose or willingness to commit the act" itself. Idaho Code § 18-101(1).

fall within the Idaho law's affirmative defense because it may not be "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(ii); *see* US Br. at 9-11, 15; Fleisher Decl. ¶¶ 12-27. In response, both the State and the Legislature try to avoid a conflict between EMTALA and § 18-622 by arguing that every single one of those conditions was "life-threatening," such that it was permissible under Idaho law for the pregnancy to be terminated. *See* Idaho Br. at 11-13; Legisl. Br. at 7-8; White Decl. ¶ 2 ("It is my opinion that every one of the five examples provided by Dr. Fleisher present a life-threatening situation."); *see also* French Decl. ¶¶ 29-30; Reynolds Decl. ¶ 7.

As an initial matter, even if § 18-622's affirmative defense were understood to apply to "life-threatening conditions," that still would not resolve the obvious textual conflict between § 18-622's narrow defense and EMTALA's much broader definition of when treatment is required, *i.e.*, for an emergency medical condition that could result in "placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A). That textual discrepancy alone is sufficient to conclude that the two statutes directly conflict and thus § 18-622 is preempted as to EMTALA-required care.

Even setting that aside, however, this argument fails on its own terms. The premise of the argument is that, under § 18-622, it is lawful to perform an abortion in response to a "life-threatening condition." But that is not what the statute's affirmative defense says—it applies when "the abortion was *necessary to prevent the death* of the pregnant woman." § 18-622(3)(a)(ii) (emphasis added). Neither the State nor the Legislature provides a basis for equating "necessary to prevent . . . death" with "life-threatening," and the phrases clearly have different meanings.

First, "necessary" is a definite term whereas "threatening" expresses a possibility. When engaging in statutory interpretation, the Idaho Supreme Court "begins with the dictionary definitions." *Idaho v. Clark*, 484 P.3d 187, 192 (Idaho 2021). As the Idaho Supreme Court has recognized, "'[n]ecessary' means 'indispensable.'" *City of Pocatello v. Peterson*, 473 P.2d 644, 648 (Idaho 1970) (citing

Black's Law Dictionary). Merriam-Webster similarly defines "necessary" as "absolutely needed: Required." *Necessary*, Merriam-Webster Dictionary Online, https://perma.cc/4DNK-AVJC. By contrast, the word "threatening"—as in the case of a "life-threatening" condition—is not nearly as definite. *See Life-Threatening*, Black's Law Dictionary (11th ed. 2019) ("Of, relating to, or involving illness, injury, or danger that could cause a person to die"); *Threatening*, Merriam-Webster Dictionary Online, https://perma.cc/TPH7-XPCE (defining "threatening" as "expressing or suggesting a threat of harm, danger"; "indicating or suggesting the approach of possible trouble or danger"). A condition that *threatens* a patient's life may not *necessarily* result in death in the absence of an abortion, which confirms that § 18-622's affirmative defense is narrower than the State's portrayal and EMTALA.

Indeed, the surrounding statutory context confirms that "necessary to prevent . . . death" was not intended to overlap with "life-threatening conditions," let alone EMTALA's scope. The Idaho Legislature has proven that when it wants to provide a broader exception for abortions—beyond just those "necessary to prevent . . . death"—it knows how to do so. For example, § 18-8804(1) prohibits certain abortions "except in the case of a medical emergency," which is defined to mean a condition "necessitat[ing] the immediate abortion of [a woman's] pregnancy to avert her death *or for which a delay will create a serious risk of substantial and irreversible impairment of a major bodily function*." Idaho Code § 18-8801(5) (emphasis added). Idaho's twenty-week ban on abortions contained a very similar exception, *see id.* § 18-505, as does the definition section applicable to § 18-622 itself. *See* Idaho Code § 18-604(9).

The Legislature's deliberate choice to allow for an affirmative defense only where "necessary to prevent the death" of the pregnant person—and not, for example, in a "medical emergency" as defined in § 18-604(9)—demonstrates that the Legislature intended for the affirmative defense in § 18-622 to apply in a narrower set of circumstances. *See Idaho v. Yager*, 85 P.3d 656, 666 (Idaho 2004) ("Where a statute with respect to one subject contains a certain provision, the omission of such provision from a similar statute concerning a related subject is significant to show that a different

intention existed."). Indeed, the Legislature conceded as much in its intervention motion—highlighting that § 18-8801(5) "has a broader definition of 'medical emergency' than does the 622 Statute," and the Legislature viewed that broader definition as being more in line with EMTALA, Dkt. 15-1 at 2, which means that the narrower version in § 18-622 does *not* align (and directly conflicts) with EMTALA.

Thus, the plain text of § 18-622's affirmative defense is narrower than EMTALA and does not even encompass care in "life-threatening situations" as the State suggests. In cases where a patient has a medical condition requiring abortion that seriously threatens the patient's health but is not yet *guaranteed* to result in their death, EMTALA requires such care whereas § 18-622 prohibits it, which means § 18-622 is preempted as applied to such care.

3. Factually, the Affirmative Defense Does Not Cover All EMTALA-Protected Abortions

Even if the affirmative defense extended to abortions provided in "life-threatening situations" as the State and Legislature suggest, § 18-622 would still conflict with EMTALA. Federal law authorizes stabilizing treatment—including, in some situations, abortions—not just when necessary to prevent death, but also where necessary to prevent "placing the health of the individual … in serious jeopardy," "serious impairment to bodily functions," or "serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A); *see* US Br. at 15. Both Defendants argue that the United States has failed to demonstrate that abortions are provided when there is a serious risk to health, bodily functions, or organs—but not to a pregnant person's life—and, thus, that there is no actual conflict between federal and state law. *See e.g.*, Idaho Br. at 12-13; Legisl. Br. at 7-8. But that is incorrect.

First, the State, the Legislature, and their declarants suggest that a bright line exists between an emergency medical condition where a patient's health or bodily functions are in danger and one where her life is at risk. *See, e.g.*, Idaho Br. at 12; Legisl. Br. at 7 (citing French Decl. ¶¶ 17-29, 30-55; Reynolds Decl. ¶ 7). But "[l]ife and health exist on a fragile and shifting continuum." Dkt. 62 at 16; *see*

also Fleisher Supp. Decl. ¶ 7, Ex. H; Corrigan Supp. Decl. ¶¶ 8-10, Ex. I. As Dr. Fleisher explained in his original declaration, "in some cases where the patient's health is unambiguously threatened, it may be less clear whether there is also a certainty of death without stabilizing treatment." Fleisher Decl. ¶ 12; *see also* Huntsberger Decl. ¶¶ 8-11, Ex. J. EMTALA requires stabilizing treatment based on that threat to health, *see* 42 U.S.C. § 1395dd(b)(1)(A), (e)(1)(A); but Idaho law requires the physician to wait until she is comfortable that there is sufficient evidence to convince a jury that termination of pregnancy is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(3)(a)(ii). That is a clear conflict between state and federal law, and "EMTALA does not allow leaving the patient untreated when doing so would irreparably risk or harm their health." Fleisher Decl. ¶ 12. When abortion is the stabilizing treatment, that care should be provided "rather than waiting to see if and/or when the patient's condition worsens to the point that they are about to die[.]" Fleisher Supp. Decl. ¶ 7; *see also* Huntsberger Decl. ¶¶ 12-15; Corrigan Supp. Decl. ¶¶ 8-13.

Second, Defendants are incorrect that, as a factual matter, interpreting the affirmative defense to mean "life-threatening" would cover all pregnancy terminations covered under EMTALA. *See* Idaho Br. at 11; Legisl. Br. at 8. Their declarants do not dispute that termination of pregnancy could be the appropriate stabilizing treatment for any example provided by the United States' declarants, *see* Part II.A, *supra*; rather, they assert that the abortions performed were necessary to save the patient's life. Setting aside these declarants' overbroad (and atextual) interpretation of the affirmative defense, their arguments disregard the actual statements in the declarations.

Dr. Fleisher, for example, described several conditions that—although they *could* be life-threatening for certain patients—may involve only threats to health, organs, or bodily functions for other patients. *See* Fleisher Decl. ¶ 15 (heart failure could threaten "impairment or severe dysfunction of bodily organs (such as the lungs, heart, and kidneys)"), ¶ 17 ("eclampsia can cause coma, pneumonia from the aspiration of stomach contents, kidney failure"), ¶ 19 (septic infection "can lead to kidney

failure"), ¶ 21 ("uncontrolled bleeding" can "result in organ dysfunction such as kidney failure"); *see also* Corrigan Supp. Decl. ¶ 8. The State's and Legislature's version of the affirmative defense—allowing treatment only in threats to *life*—still prohibits treatment that EMTALA requires, *i.e.*, when an emergency medical condition poses some of these threats to health but may not yet result in a threat to life. *Cf.* Fleisher Decl. ¶ 23 (discussing "[h]ow emergency conditions present in a pregnant patient will often vary depending on the patient's specific circumstances"). Indeed, Dr. Fleisher's supplemental declaration further elaborates on one such concrete example: a patient diagnosed with preterm premature rupture of membranes (PPROM), which currently threatens bodily functions and organs (*e.g.*, her uterus and future fertility), but which would not yet constitute a life-threatening condition. *See* Fleisher Supp. Decl. ¶ 6.

The Idaho providers, moreover, addressed similar situations. Dr. Cooper, for instance, described a situation in which Jane Doe 1 presented to the hospital with fetal triploidy and preeclampsia with severe features. Cooper Decl., Dkt. 17-7 ¶ 6. The patient was "at risk for stroke, seizure, pulmonary edema, [and] development of HELLP syndrome," but rather than wait for her life to be in jeopardy, Dr. Cooper recommended termination of the pregnancy "to stop her disease progression." *Id.* EMTALA permitted her to take that action when there was only a risk—at that moment in time—to her health, bodily functions, and organs; contrary to Defendants' position, she did not wait until the situation deteriorated further to become life-threatening, and EMTALA would not have allowed her to do so. *See also* Cooper Supp. Decl. ¶ 3, Ex. K.

Further, Dr. Cooper's and the other supplemental declarations make clear that, consistent with EMTALA, physicians in Idaho perform "abortions" before emergency medical conditions deteriorate into life-threatening ones. As with Dr. Fleisher, Dr. Cooper explains PPROM can initially present in a variety of different ways, some of which may only involve threats to health, organs, and bodily functions but which still require stabilizing treatment. Cooper Supp. Decl. ¶ 5. Similarly, the need to

treat preeclampsia "is not always to prevent death" but may be "to avoid further deterioration, physical harm, and threat to future fertility and long-term health." *Id.* ¶ 3. Dr. Huntsberger also explains that many ectopic pregnancies are treated by prescribing methotrexate to end the pregnancy without need of surgical intervention, because surgery greatly increases the risk of rupturing the fallopian tube and by extension decreasing fertility. Huntsberger Decl. ¶ 12. Predicting when an ectopic pregnancy will result in rupture of the fallopian tube is not ordinarily possible, and for that reason, physicians act immediately to resolve the emergency medical condition when it presents as a threat to the patient's health and organs rather than her life. *See id.* ¶¶ 11, 13.

Pregnant patients seek treatment for these emergency medical conditions in emergency departments throughout Idaho, and under federal law, covered hospitals must offer stabilizing treatment for conditions that endanger a patient's health. Idaho's affirmative defense does not extend to that care, however, even under Defendants' atextual and overbroad interpretation. Section 18-622 is accordingly in direct conflict with EMTALA by prohibiting care that EMTALA requires.

C. Idaho Law Conflicts with EMTALA By Allowing Prosecution and Disciplinary Proceedings for All Abortions Regardless of Circumstances

Additionally, § 18-622 directly conflicts with EMTALA because, regardless of the scope of the law's affirmative defense, that affirmative defense structure *itself* stands as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," in violation of EMTALA's preemption provision. *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993).

Notably, neither the State nor the Legislature disputes that § 18-622 allows medical professionals to be indicted, arrested, and criminally prosecuted for *every* abortion, regardless of the abortion's circumstances. The Legislature tries to salvage the law by resorting to notions of prosecutorial discretion. *See* Legisl. Br. at 9-10; Loebs Decl., Dkt. 71-6. But this argument concedes that § 18-622 criminalizes life-saving care, because the "necessary to prevent . . . death" standard has been relegated to an affirmative defense. *See, e.g.*, *United States v. Sisson*, 399 U.S. 267, 288 (1970) ("It

has never been thought that an indictment, in order to be sufficient, need anticipate affirmative defenses."); *Idaho v. Barton*, 297 P.3d 252, 255 (Idaho 2013); *Idaho v. Segovia*, 457 P.2d 905, 908 (Idaho 1969). Thus, even though both the Legislature and State accept that termination of pregnancies is medically necessary for a range of conditions, they nonetheless concede that each time a physician performs that "heroic life-saving surgery," French Decl. ¶ 33, the physician remains subject to indictment, arrest, and criminal prosecution—a clear conflict with EMTALA's text and purpose of *requiring* such medical care. *Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001). It is of little comfort to a physician, whose freedom and livelihood are on the line, that the Legislature claims in its briefing that some prosecutors may not fully enforce Idaho's much-touted new law. Corrigan Supp. Decl. ¶ 14; Huntsberger Decl. ¶ 20; Cooper Supp. Decl. ¶ 9.

Even on its own terms, the Legislature's reliance on prosecutorial discretion fails. The Legislature has submitted a single declaration from a single county prosecutor, who obviously lacks authority to bind any of the other 43 elected county prosecutors, let alone grand juries or citizens who might independently seek to initiate criminal proceedings, or any of the disciplinary boards that might pursue license revocation proceedings. *Cf.* Idaho Code § 19-1108 (grand juries); *Idaho v. Murphy*, 584 P.2d 1236, 1241 (Idaho 1978) (citizen complaints); § 18-622(2). More fundamentally, the Ninth Circuit has expressly held that officials' "promise of self-restraint does not affect our consideration of the ordinances' validity" under preemption doctrine. *City of Arcata*, 629 F.3d at 992; *see also Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 882 (2000) ("[T]his Court's pre-emption cases do not ordinarily turn on such compliance-related considerations as whether a private party in practice would ignore state legal obligations . . . or how likely it is that state law actually would be enforced.").

The State, for its part, does not deny that every provider is subject to disciplinary proceedings and prosecution even when they provide life-saving care, and instead tries to defend the law indirectly. First, the State contends that there is no "direct conflict" because it remains possible for physicians to

comply with both § 18-622 and EMTALA. Idaho Br. at 15. But that is inconsistent with the Ninth Circuit's interpretation of EMTALA's preemption provision as extending to a "state law [that] is an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *Draper*, 9 F.3d at 1393. Here, § 18-622's affirmative defense structure poses an obstacle to EMTALA-required care—because even when federal law *compels* a physician to provide such care, the physician still risks indictment, arrest, pretrial detention, and a trial where the physician bears the burden of proof on this critical issue, all under threat of a felony conviction with a minimum two-year sentence. For those physicians "faced with the obligation to comply with [Idaho's] law and left only with an affirmative defense," before providing care they are forced to ask: "Is any risk of death sufficient? Must the risk be greater than 50%? 75%?" Corrigan Supp. Decl. ¶ 14. That alone frustrates EMTALA.

Second, the State argues for a presumption against preemption "in a field which the States have traditionally occupied." Idaho Br. at 15. But when a "statute contains an express pre-emption clause," as EMTALA does here, "we do not invoke any presumption against pre-emption." *Puerto Rico v. Franklin Calif. Tax-Free Tr.*, 579 U.S. 115, 125 (2016); *see also Sabri v. United States*, 541 U.S. 600, 608 n.* (2004) (federal spending power applies with equal force when Congress legislates "in an area historically of state concern").

Third, the State disputes the "chilling effect" experienced by medical providers, pointing out EMTALA's civil liability provisions. *See* Idaho Br. at 16. But those civil liability provisions apply only if a hospital *fails* to provide EMTALA-mandated care, *see* 42 U.S.C. § 1395dd(d)(2)(A), so it is unclear what relevance they have to evaluating the chill caused by § 18-622, which *prohibits* such care and exposes such care to criminal prosecution. If anything, those civil liability provisions only highlight the impossible position facing providers because of § 18-622. Moreover, the "chill" here is well-documented both factually and legally. Several Idaho-based providers have confirmed that, because of § 18-622, the threat of prosecution would interfere with the timely provision of medically necessary

and ethically appropriate care for their patients. *See* Corrigan Decl. ¶¶ 31-35; Corrigan Supp. Decl. ¶ 11; Cooper Decl. ¶ 12; Cooper Supp. Decl. ¶¶ 7, 9; Seyb Decl. ¶¶ 13-14; Huntsberger Decl. ¶¶ 19-20.[3] And legally, the threat of civil and criminal sanctions for engaging in conduct required by federal law is more than enough to establish obstacle preemption. *See Chamber of Commerce of U.S. v. Bonta*, 13 F.4th 766, 781 (9th Cir. 2021) ("much like a state may not 'prohibit[ ] outright'" conduct protected by federal law, a state likewise cannot "impose civil or criminal sanctions on individuals or entities for the act" encouraged by federal law); *see also Rice v. Norman Williams Co.*, 458 U.S. 654, 661 (1982) (state law is preempted if it "places irresistible pressure on a private party to violate [federal law] in order to comply with the statute"); *Nash v. Fla. Indus. Comm'n*, 389 U.S. 235, 239 (1967).

At bottom, § 18-622 represents a substantial obstacle to providing the emergency medical treatment required by EMTALA and is therefore preempted. The availability of an affirmative defense, to be proven at a criminal trial, by a preponderance of the evidence, does not alleviate this conflict.

III. The Equitable Balance Confirms an Injunction Is Warranted

As previously discussed, the balance of the equities underscores that preliminary injunctive relief is appropriate here. A preliminary injunction will prevent widespread harm to pregnant patients within Idaho, protect Congress's public policy choice, and preserve the integrity of the Medicare program. Meanwhile, § 18-622 is not (and never has been) in effect. Enjoining that law's application to a subset of federally mandated medical care will cause no tangible harm to Idaho.

Throughout its brief, the Legislature describes the threatened denial of medical care to patients as a mere "thimble" that is "empty." Legisl. Br. at 2-3, 8. Under federal law, however, *every* person is

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[3] The Legislature tries to dispute the validity of this "chill" through Dr. Reynolds's declaration, in which she states that "[n]either I nor, in my opinion, any practicing Ob-Gyn would reasonably fear criminal prosecution under the 622 Statute" in circumstances that necessitate "an emergency medical procedure necessary to preserve the life of the mother." Reynolds Decl. ¶ 14. Dr. Reynolds—a Nevada-based doctor—is not competent to testify about Idaho-based physicians' fears of prosecution under Idaho law. *Cf.* Corrigan Supp. Decl. ¶ 3. And Dr. Reynolds nowhere acknowledges that § 18-622 contains only an *affirmative defense* for abortions necessary to prevent death.

guaranteed emergency care within EMTALA's scope, and § 18-622's prohibition of such emergency care—even if applicable only to a single person—is sufficient to establish a violation of the Supremacy Clause and, consequently, irreparable harm. *See Arizona*, 641 F.3d at 366 (recognizing that establishing a Supremacy Clause violation also establishes irreparable harm).

The Legislature relies on "statistics" purportedly showing that only five emergency abortions have occurred in recent years. *See* Legisl. Br. at 8. Of course, even that showing would be enough for irreparable harm. Regardless, as the Legislature admits, their statistical categories are so circumscribed that they say *nothing* about emergency medical conditions requiring termination of the pregnancy for the vast majority of individuals. *Cf. Idaho Vital Statistics - Induced Abortion 2020*, Idaho Department of Health and Welfare (Jan. 2022), Ex. L, at 10, 14 (confirming that the Legislature's statistical categories are essentially an empty set).

Finally, the State argues that it is simply "regulating abortion through a criminal statute of general applicability," which does not "regulat[e] Medicare or the hospitals' participation in Medicare." *Id.* at 18-19. Regardless of the validity of Idaho's law generally, however, it interferes with the integrity of Medicare by criminalizing medical care that, as a condition of receiving federal funding, covered hospitals are required to offer. And the generality of the State's law does not change that, with respect to EMTALA-required care, the law directly conflicts and therefore is invalid under the Supremacy Clause. Given the lack of any tangible harm to Idaho from a temporary injunction against § 18-622's enforcement as to EMTALA-required care, the equitable balance confirms that a preliminary injunction is warranted here.

CONCLUSION

For the foregoing reasons, the Court should enter a preliminary injunction prohibiting the State of Idaho—including all its officers, employees, and agents—from enforcing Idaho Code § 18-622(2)-(3) as applied to EMTALA-mandated care.

Dated: August 19, 2022

Respectfully submitted,

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EXHIBIT H

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329

SUPPLEMENTAL DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties. The following statements are provided as a supplement to the prior written testimony that I submitted in relation to this case on August 8, 2022.

1. I have reviewed the Declarations of Dr. Richard Scott French (the "French Declaration"), ECF 75-1, and Dr. Kraig White (the "White Declaration"), ECF 66-1. Both the French Declaration and the White Declaration discuss my prior declaration, including my testimony explaining that the appropriate stabilizing treatment for some emergency medical conditions experienced by pregnant patients is termination of pregnancy. French Decl. ¶¶ 17-29; White Decl. ¶¶ 2-7.

2. Both Dr. French and Dr. White agree with my prior statements that termination of pregnancy is the necessary and appropriate medical treatment for pregnant patients under the circumstances discussed. As Dr. French explains: "[E]very one of the

five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that a life-saving surgery would more likely than not result in the termination of the pregnancy." French Decl. ¶ 29. Dr. White similarly agrees. White Decl. ¶¶ 2-7.

3. The only point of disagreement with my prior testimony appears to be Dr. French's interpretation of the Idaho statute that is challenged in this case. Dr. French states that "life-saving surgery is not an abortion, and the language in the Idaho statute permits such life-saving surgeries/procedures." French Decl. ¶ 29. Dr. French's interpretation is inconsistent with my reading of the Idaho statute, which defines abortion to mean "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." Idaho Code § 18-604(1). While I agree that the statutory definition of "abortion" in the Idaho Code covers some procedures that would not be characterized as an abortion *in the medical community*, the language of the Idaho statute appears to cover any medical treatment that requires intentional termination of a pregnancy regardless of the circumstances.

4. Additionally, it appears that Dr. French and Dr. White believe that the Idaho statute does not threaten criminal liability when termination of the pregnancy occurs in response to a "life-threatening" condition. French Decl. ¶¶ 29-30; White Decl.¶ 2. From a medical perspective, I do not believe "life-threatening," which generally implies only a *risk* of death, necessarily has the same meaning as the Idaho law's affirmative defense—

"necessary to prevent . . . death"—which generally implies avoiding a certainty (or at least very high probability) of death.

5. Regardless, I do not believe "life-threatening" fully encompasses all potential emergency medical conditions for which a pregnant patient might be entitled to stabilizing treatment under EMTALA. Specifically, the State's declarations do not address situations in which termination of pregnancy is necessary to protect a patient's health, or to ensure that a pregnant patient will not suffer a serious impairment to their bodily functions or serious dysfunction of any bodily organ or part, but where the patient's life is likely not in danger at that point in time. As explained in my prior declaration, many pregnancy conditions pose serious risks to the patient's health that are appropriately stabilized through termination of pregnancy, even though a physician may not be able to establish or know that termination of pregnancy is "necessary to prevent the death of the woman" at that time. In those instances, termination of pregnancy would be necessary to protect the patient's health, even though death is not immediately threatened.

6. For example, I previously discussed the scenario of a patient who comes to an emergency department with preterm premature rupture of membranes ("PPROM"), which is a premature breaking open of the amniotic sac that increases the risk of severe intra-amniotic infection. If PPROM is diagnosed, the patient faces serious risk of infection which could impair the function of any number of organs or bodily functions. As an example, developing significant infection in the uterus could seriously impair the patient's reproductive organs if the condition is allowed to deteriorate. Providing stabilizing treatment in the form of termination of pregnancy at the point of diagnosis would be an appropriate means to preserve the patient's reproductive organs at that time. If stabilizing

treatment were withheld at that point in time, the infection could only worsen and treatment at a later point would present significantly higher risk of complications, potentially requiring a hysterectomy and/or harming their future fertility. If a patient is diagnosed with PPROM before severe infection occurs, a patient may not immediately face a life-threatening risk. However, immediate treatment through termination of pregnancy may be necessary because delaying treatment would allow the condition to progress, thereby threatening other bodily organs and functions, including but not limited to future fertility. Under those circumstances, the patient and physician may decide that termination of pregnancy may be the appropriate stabilizing treatment to protect the patient from organ dysfunction or other bodily impairment, even though the stabilizing treatment is not yet in response to a life-threatening circumstance.

7. In general, medical risk to individual patients exists along a continuum, and there are no medical "bright lines" specifying when exactly a condition becomes "life-threatening" or "necessary to prevent the death" of the pregnant patient. Even in situations where it is unclear whether the patient's life is in immediate danger, it may be apparent that the patient's condition will continue to deteriorate absent stabilizing treatment through termination of pregnancy. Under those circumstances, terminating the pregnancy to avoid the patient's health falling into serious jeopardy, bodily functions being seriously impaired, or organs becoming seriously dysfunctional (rather than waiting to see if and/or when the patient's condition worsens to the point that they are about to die) may be the appropriate recommendation from the physician as medically necessary and is what EMTALA requires.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 18th day of August, 2022 in Philadelphia, PA.

Lee A. Fleisher, M.D.

EXHIBIT I

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **REPLY DECLARATION OF DR. EMILY CORRIGAN**

REPLY DECLARATION OF DR. EMILY CORRIGAN IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Emily Corrigan, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at Saint Alphonsus Regional Medical Center in Boise, Idaho and I previously submitted a declaration in this case. I have now reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. As with my first declaration, unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

The State's Physician Declarations Do Not Reflect Relevant Personal Experience or Risk.

2. To begin, my overall reaction having reviewed the declarations of Drs. White, Reynolds and French is that none of them face the same risk of criminal prosecution for violating

Idaho Code § 18-622 as myself, Dr. Seyb, Dr. Cooper, and most other Idaho physicians and nurses who must comply with EMTALA while treating critically-ill pregnant patients.

3. Although Dr. Reynolds says she was raised in Idaho, after she completed her residency in Nevada she chose to continue practicing medicine there where I understand abortion to be legal. *See* Dr. Reynolds Decl. ¶ 2. She does not indicate in her declaration any intention to return to Idaho to help either patients in Idaho or her physician colleagues deal with these new laws, which have no effect on her living and practicing in Nevada. If anything, her declaration is evidence of Idaho's dire OB/GYN shortage as compared to more urban areas like Las Vegas where she trained, has practiced ever since, and is part of a very large group of physicians. The OB/GYN residency program in Nevada will continue to produce six new OB/GYN physicians per year to supply their workforce. Idaho hospitals will have to convince OB/GYN physicians from out of state to move here and practice under the stressful circumstances created by Idaho Code § 18-622 and our already understaffed OB/GYN Departments.

4. Dr. French does not state in his declaration where he currently is practicing medicine but he speaks of his time in Idaho in the past tense only. *See* Dr. French Decl. ¶¶ 5, 6. His online Doximity profile indicates that he is currently practicing in Hawaii. Abortion healthcare is not currently under legal threat in Hawaii.

5. Dr. White says that he is practicing in Moscow, Idaho, a town that is only 8 miles from Pullman, Washington. Pullman Regional Hospital features a level IV trauma center, so any high-risk patient that Dr. White encounters could quickly and easily be transferred to a hospital in a state where abortion is legal.

6. Additionally, Dr. White says that he is working as a Family Medicine Physician in the Emergency Department at a small hospital. In my experience, if a pregnant patient is having

a significant complication, the Emergency Department provider requests a consultation from an OB/GYN who then assumes management of the patient.[1] Reading his declaration, I noted that while Dr. White says that in the last 6 years he has treated "life-threatening situations that have included obstetrical emergencies," he does not say whether he has ever personally made the decision to terminate a patient's pregnancy to stabilize her condition. Also, complex obstetric patients are usually transferred from a critical access hospital to a tertiary care center before a decision is made regarding an emergency abortion. As such, there is nothing in his declaration to suggest that Dr. White has ever faced the situations that Drs. Seyb, Cooper, and I have faced many times in our careers, that we described in our declarations, and that is at the crux of the conflict between federal and state law if Idaho Code § 18-622.

The State's Physician Declarations Are Wrong About "Necessary to Prevent Death"

7. Each of the State's physician declarations suggests that termination of the pregnancy was necessary to save the pregnant patient's life in each of the cases I discussed. Having not treated those patients or studied their files, those physicians do not speak from experience and are simply wrong. There are several reasons why.

8. First, it is medically impossible to say that death was the guaranteed outcome for Jane Doe 1, 2, and 3 if we had not terminated their pregnancies when we did. None of their conditions *necessarily* would have ended in death. Jane Doe 1 could have developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but could still be alive. Jane Doe 2 possibly would have developed kidney failure requiring lifelong dialysis or hypoxic

[1] Patients with emergency pregnancy-related conditions are frequently triaged and treated in a hospital's labor & delivery department, which is considered part of the "emergency department" for purposes of EMTALA.

brain injury but escaped death. Jane Doe 3 was at risk for stroke and severe lung injury but may have survived her illness. Each of these women potentially would have had to live the remainder of their lives with significant disabilities and chronic medical conditions as a result of their pregnancy complication. If I was asked if the abortion was necessary to prevent the death of the patient in each of those cases, I could not necessarily say yes with absolute certainty. I do not believe that any physician could. That said, in each case, abortion was necessary to stabilize the patient's health.

9. While the State's physician declarations speak in terms of absolutes, medicine does not work that way in most cases. Death may be a possible or even probable outcome, but different outcomes may also be possible or probable. This is why doctors frequently refuse to answer the question, "What are my chances?" I frequently tell my patients that I do not possess a "crystal ball" that informs me of exactly what the future holds for them, I can only make an educated guess based on my training and experience. We can provide empirical data on how many patients survived a particular condition, if that data was collected and verified (usually through peer review). But we can only rarely predict with certainty a particular outcome. This is why we follow the standard of care—something that *is* knowable and is consistent with our obligations under EMTALA. And this is also why the Idaho law will have a chilling effect on physicians in treating pregnant patients facing health emergencies.

10. Second, the State's physician declarations simply assume that their interpretation of the Idaho law is the correct one, ignoring that the law does not define when a procedure would be deemed "necessary to prevent the death of the pregnant woman." For those of us faced with the obligation to comply with that law and left only with an affirmative defense, we must ask: Is any risk of death sufficient? Must the risk be greater than 50%? 75%? Or must the physician

wait until the patient's heart has stopped beating to provide the termination and begin resuscitative efforts? Idaho Code § 18-622 does not say. What we can say is that a physician's good-faith belief that it was necessary is *not* enough, as it appears the law does not have any sort of good-faith exception. Just because one physician says he or she believes termination is "necessary" to prevent the pregnant patient's death does not mean all physicians would agree, and certainly does not guarantee all prosecutors, judges, and jurors untrained in medicine would agree. Instead, a physician must rely on hope that a judge or jury would interpret what is "necessary" in the same way as the physician.

11. Third, even if death is eventually the necessary outcome absent termination of a pregnancy, the Idaho law tells physicians to wait until death is near-certain and in the meantime the patient will experience pain and complications that may have lifelong disabling consequences. Even if a patient is ultimately provided the medically necessary care, Idaho Code § 18-622 will delay that care until a debate determines whether it is truly "necessary to prevent the death of the pregnant woman." In my view, the State's physician declarations unrealistically downplay the reason physicians will wait until they are sure an abortion is necessary to prevent death. A physician administering an emergency abortion in Idaho would be risking their professional license, livelihood, personal security, and freedom. Our malpractice insurance may not cover us for performing an act that some may view as a crime. Of course, we may hesitate to provide the same care after the Idaho law is effective—the law is designed for that very purpose.

12. Fourth, the State's physician declarations ignore that it is not only physicians who perform abortions who may be exposed to serious risk. Idaho law also exposes nurses and others who assist doctors to criminal and license-suspension risk. As a result, there will be some cases where even if a physician may be comfortable proceeding, she may have no nurse or other staff to

assist because of the fear that this law has instilled in healthcare workers in Idaho. That too will undermine patient care, causing harm to patients and increasing the risk associated with the abortion being performed.

13. Just because out-of-state doctors do not fear prosecution under Idaho Code § 18-622 does not mean that those of us who actually do practice in Idaho feel the same way. I have said to the administration at my hospital that the OB/GYN Physicians in Idaho are "bracing for the impact" of this law, as if it is a large meteor headed towards Idaho. The OB/GYN and Maternal Fetal Medicine physicians who work at tertiary care hospitals in Boise feel this trepidation most acutely because we receive the most complex cases from other hospitals in the state that have fewer resources. Dr. Cooper, Dr. Seyb, and I are all part of this group of physicians that is most at risk from the implications of this law. There are no declarations submitted in support of this law from any physician with this level of current and intimate knowledge of the risks and challenges we are facing. If this law goes into effect, there will be serious negative consequences for patients and healthcare workers alike. While the pregnant people of Idaho will likely suffer serious physical and emotional trauma or even death as a result of this law, the OB/GYN physicians who practice here will face the untenable situation of making decisions for the care of critically ill patients while facing an impossible choice between complying with either state or federal law but not both.

The Prosecutor's Declaration Provides Little to No Comfort.

14. I reviewed the declaration from Prosecuting Attorney Grant Loebs. A declaration from one prosecutor in Twin Falls County does not provide me with any comfort that I would not be criminally prosecuting for terminating a patient's pregnancy where required by EMTALA but not 100% necessary to prevent imminent death to the patient. Idaho has lots of prosecutors. They may have different views of how to exercise their discretion. Some may even think that they have

an obligation to enforce the law in Idaho and may disagree that it was passed only to send a message. And other prosecutors who haven't even been elected yet may have still other views of the law. The consequences of a criminal prosecution are so serious, even if I could present a defense, that Idaho Code § 18-622 is necessarily going to change how emergency medical care is administered in Idaho, even if one prosecutor promises he doesn't plan to enforce it.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/18/22
Date

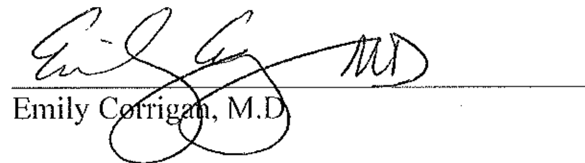
Emily Corrigan, M.D

EXHIBIT J

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF DR. AMELIA HUNTSBERGER**

DECLARATION OF DR. AMELIA HUNTSBERGER IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Amelia Huntsberger, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist (Ob/Gyn) physician at Bonner General Health, a critical access hospital in Sandpoint, Idaho. Bonner General Health is a small, rural hospital that provides Labor and Delivery services. The nearest Neonatal Intensive Care Unit (NICU) is 45 miles from Sandpoint.

2. In 2008, I graduated from the University of Washington School of Medicine which is the regional medical school for Washington, Idaho, Wyoming, Montana and Alaska. I completed my residency in Obstetrics and Gynecology at the University of Michigan in Ann Arbor in 2012. I am board certified in General Obstetrics and Gynecology since 2015.

3. I was invited to join the Idaho Perinatal Project advisory board in 2018. Improving pregnancy outcomes by reducing maternal and infant morbidity

and mortality is the mission of the Idaho Perinatal Project. I am a member of the Idaho Maternal Mortality Review Committee. I am currently the Idaho Section Chair of the American College of Obstetricians & Gynecologists.

4. I moved to Sandpoint, Idaho in 2012 and began working as an Ob/Gyn at Bonner General Health.

5. I grew up in a rural area and feel patients in rural areas deserve high quality, compassionate health care just like patients in more populated areas. Serving a rural community has been my goal since I was a medical student.

6. I have reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. The facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

Abortion Is Sometimes Medically Necessary Even When It Is *Not* Necessary to Prevent the Mother's Death.

7. The physician declarations from Drs. White, Reynolds, and French seem to suggest that whenever abortion is medically necessary, it is necessary to prevent the mother's death. That is simply not the case.

8. At Bonner General Health, we do not perform purely "elective abortion." However, I have personally treated patients whose health condition requires abortion as stabilizing care—even if those patients were not necessarily facing death in the absence of an abortion.

9. A relatively common example of this is ectopic pregnancy. Not every patient with an ectopic pregnancy will die without an abortion. But terminating an ectopic pregnancy is the standard of care to prevent serious risks to the mother, including internal bleeding, injury to the fallopian tube or other organs in the abdominal cavity, impaired fertility, and in some cases, death.

10. I have reviewed the declaration of Dr. Reynolds stating that termination of ectopic pregnancy is not an abortion. While Dr. Reynolds may not consider the termination of ectopic pregnancy to be abortion, she does not acknowledge how Idaho law defines abortion. Unlike Dr. Reynolds, who practices in Las Vegas, Nevada, I practice medicine in Idaho. I have reviewed Idaho law and it defines abortion as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean the use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization or the implantation of a fertilized ovum within the uterus." An ectopic pregnancy is a "clinically diagnosable pregnancy" even if the fetus is not viable, and Idaho law has no exceptions for lethal anomalies. There are various means to terminate an ectopic pregnancy, all of which are intended to cause the death of the fetus and all of which are performed with knowledge that they will cause the death of the fetus.

11. For example, I treated a patient in her mid-30s who presented to the hospital with spotting and pelvic pain. An ultrasound showed an ectopic pregnancy

with a fetal heartbeat. Free fluid, presumed to be blood, was seen on the pelvic ultrasound. I counseled the patient about the risks, benefits, and alternatives available to her and she elected and consented to undergo laparoscopy with removal of the ectopic pregnancy. At the time of surgery, there was 750 mL of blood in her abdomen despite normal blood pressure and pulse. A patient with stable vital signs like this one is experiencing a health emergency—her health is in "serious jeopardy" within the meaning of EMTALA. However, a patient with stable vital signs may not appear to be near death. If I had let her condition deteriorate before performing a life-saving abortion, however, she would have faced increased pain, risk of further hemorrhage inside the abdomen, anemia, possible development of disseminated intravascular coagulopathy (DIC), need for blood transfusion and other blood products. She also could have died had we waited too long and been unable to manage the complications that may have arisen. Ectopic pregnancy is a potentially life-threatening diagnosis. The timeline for it to develop into an acutely life-threatening condition is difficult to precisely predict, even for a medical expert. Stabilizing treatment with abortion as defined by Idaho law was necessary to prevent a life-threatening situation from evolving.

Waiting Until Abortion Is Necessary to Prevent the Patient's Death Will Cause Serious Harm.

12. With ectopic pregnancies and pregnancy of unknown location, waiting until an abortion is necessary to prevent death is harmful and dangerous. In some ectopic pregnancies and pregnancies of unknown location, treatment with methotrexate may be offered. Methotrexate is a chemotherapy drug used to kill

rapidly dividing cells (which therefore targets pregnancy). Methotrexate can be used to "intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child" (the Idaho definition of abortion). If we must wait until a patient's death is imminent to terminate her ectopic pregnancy or pregnancy of unknown location, we can no longer use methotrexate and must provide surgical intervention. Surgical intervention carries its own risks, including potential loss of a fallopian tube, damage to nearby abdominal structures (like bladder, bowel, uterus, ovary, ureter and/or blood vessels), infection, bleeding and potential loss of the patient's ability to become pregnant naturally in the future.

13. I have personally treated patients who sadly experienced this outcome. One patient had the devastating experience of having both tubes removed for separate instances of ruptured ectopic pregnancy. As a result, she has no option for spontaneous pregnancy and would require in vitro fertilization (IVF) or adoption to grow her family. Appropriate use of methotrexate when the patient first presents with ectopic pregnancy, if successful (which it typically is), may avoid the need for surgical intervention and increase likelihood of successful future pregnancy. The total abortion ban will cause doctors to hesitate before using methotrexate, putting their patients' health and fertility at risk.

14. Another example shows the consequences of delaying an abortion. This patient was a female in her 40s with 3 living children who presented to the hospital via ambulance with heavy vaginal bleeding. She reported that she was

approximately 14 weeks gestation. She had been experiencing very heavy bleeding at home. She initially declined care including bloodwork, pelvic ultrasound and/or Ob/Gyn consultation in the ER. She was not unstable at this time, and I could not say an abortion was necessary at that time to prevent her death. However, she continued bleeding profusely in the ER until she was unable to stand due to hemorrhage causing symptomatic anemia. After a syncopal episode, she agreed to be seen by an Ob/Gyn and I was emergently called. She was pale and unable to sit up in bed due to her anemia at the time of my evaluation. She was bleeding heavily from the vagina making visualization during pelvic exam very difficult. I removed products of pregnancy from the open cervix in the ER, however, very brisk bleeding continued and she was counseled to undergo emergent D&C in the Operating Room (OR) for a second trimester incomplete abortion. I reviewed the risks, benefits and alternatives of D&C (dilation and curettage- a procedure to remove the products of pregnancy from the uterus) in addition to the risks, benefits and alternatives of blood transfusion and she consented to both. I took her to the OR for D&C. She was hypotensive and tachycardic; she was unstable at that time. She received 2 liters of IV fluids, transfusion of 3 units of packed red blood cells in the OR, another unit of packed red blood cells in the Recovery Room immediately following her surgical procedure. She received 2 units of fresh frozen plasma given her large volume blood loss. I had to order platelets from Spokane, Washington, which did not arrive until several hours later via taxi and were transfused into the patient. She stayed in the

hospital for 2 days. She received another transfusion of 2 units of blood for ongoing symptomatic anemia prior to her discharge home.

15. I provide these details regarding this patient's case because her case shows what can happen when we delay an abortion that would otherwise be the recommended medical intervention. In this case, the patient chose to delay the abortion but if Idaho Section 622 takes effect, physicians in Idaho will be forced to wait until the abortion is necessary to prevent death of the patient. Patients may experience serious complications, have negative impact on future fertility, require additional hospital resources including blood products, and some patients may die.

The Idaho Law Will Have Serious Negative Effects on Medical Care in Idaho.

16. While Drs. White, Reynolds and French suggest that the law is clear to them, it certainly is not clear to me. The goal in medicine is to effectively identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. One impact on medical care may be a reluctance to use effective, evidence-based treatments like methotrexate for ectopic pregnancy or pregnancy of unknown location.

17. Most rural hospitals in Idaho, like my own institution, were not offering "elective terminations" of pregnancies prior to the *Dobbs* decision. Yet those of us who treat pregnant patients are deeply worried about what these abortion laws will mean for the practice of routine reproductive care given the Legislature's broad definition of "abortion."

18. In rural areas, patients may live 30-60 miles or more away from medical care. There is less access to specialty care, less blood stocked in the blood bank, less access to other blood products. At the critical access hospital where I work, we don't have platelets in the blood bank as previously described. If necessary, platelets come via taxi from a neighboring state and may take hours to arrive. Most rural hospitals do not have interventional radiology (can provide additional treatment option for maternal hemorrhage), Maternal Fetal Medicine expert (high risk pregnancy doctor), nor a dedicated Critical Care doctor that manages the Intensive Care Unit (ICU). Rural hospitals, like my own, may not have dialysis capabilities. As per EMTALA, some patients will need to be transferred to a hospital that can offer a higher level of care. If there is bad weather, it is not possible to use a helicopter and then a patient will travel by ambulance 45 to 60 miles away depending on which hospital accepts the patient and/or which hospital has the resources that the patient needs. We work with the resources that we have to the best of our ability, but we don't have the same staff, equipment and resources as larger and/or urban centers. For rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA.

19. I hope that the Court takes into consideration how physicians actually practicing in Idaho and treating Idahoans perceive the law and its effect of criminalizing evidence-based medical care. A doctor practicing in Las Vegas or Honolulu does not have the same experience and does not face the same potentially life-altering dilemma that we will face if this law is allowed to take effect.

20. I have also reviewed the declaration of the attorney, Mr. Loebs, and it does not make me feel any better about how the law will negatively affect patients and physicians in Idaho. How can I trust that every prosecutor in the State has exactly the same beliefs, much less every *future* prosecutor? If the law allows prosecution, it is not reassuring that I can simply rely on the good faith of prosecutors. A prosecutor may believe that they have an obligation to enforce the law as it is written. I have a career and a family of my own so I cannot just hope that all prosecutors will exercise discretion in exactly the same way as Mr. Loebs.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 18th day of August 2022, in Sandpoint, Idaho.

8/18/2022
Date

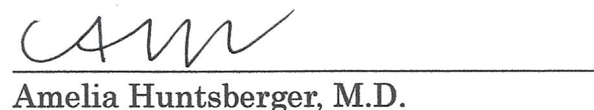
Amelia Huntsberger, M.D.

EXHIBIT K

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D.**

SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I have read the briefs submitted by the State of Idaho and the Idaho Legislature and the supporting Declarations. I submit this supplemental declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. As stated in my Declaration (Dkt.17-7), pregnancy is not always straight forward and complication free. If I terminate a "clinically diagnoseable pregnancy" the affirmative defense available to me under Idaho Code §18-622 requires me to prove that in my medical judgment and based on the facts known to me, the termination was necessary to prevent the death of the pregnant woman. The vast majority of patients do not present at death's door. For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated

treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense.

3. My patient Jane Doe 1 is just one of countless patients whom I have treated with a diagnosis of preeclampsia with severe features. Medical standard of care dictates that expectant management, or continued observation without treatment of a pregnancy with a diagnosis of preeclampsia with severe features is contraindicated in the setting of a fetus not expected to survive including those at a pre-viable gestational age. The reason for this is because preeclampsia with severe features places a patient at risk for both acute and long-term complications and the clinical course involves progressive deterioration of the maternal and fetal condition. Patients with preeclampsia with severe features may present with varying symptoms. For some it is severe hypertension, for others it is evidence of kidney or liver damage on laboratory assessment. Others present with severe intractable headache pulmonary edema and some at the extreme end of the spectrum with HELLP syndrome (hemolysis, elevated liver enzymes, low platelets). The definitive medical treatment for pre-viable preeclampsia with severe features is termination of pregnancy. The medical rationale to treat preeclampsia with severe features once it has been diagnosed is not always to prevent death; in the majority of cases it is to avoid further deterioration, physical harm, and threat to future fertility and long-term health.

4. Maternal death remains relatively uncommon which is due to contemporary and evidence based medical practices and protocols which we use to treat the patient in an appropriate and timely manner rather than waiting until they experience the anticipated and severe complications of their illness.

5. Preterm pre-labor rupture of membranes (PPROM) is a circumstance in which the amniotic sac has ruptured too early. I have treated countless patients with PPROM and for some

patients this occurs in the pre-viable or peri-viable time frame. This condition carries a multitude of risks including intra-amniotic infection, endometritis, placental abruption, and retained placenta. It can also lead to maternal sepsis, acute kidney injury, hemorrhage, need for blood transfusion, and hysterectomy. Maternal deaths due to infection do occur. The clinical presentation of PPROM can vary. In addition to abnormal leakage of amniotic fluid, some may also experience bleeding from an abruption or labor. For others, they may present with signs and symptoms of intraamniotic infection. In the pre-viable and peri-viable setting the chance of pregnancy loss is very high. The clinical course for patients with PPROM can be unpredictable. They may be stable at one moment and bleeding profusely or demonstrating systemic signs of infection the next. Having PPROM places them at risk for hemorrhage which can be further compounded by an intraamniotic infection or sepsis. Hemorrhage, if significant and unresponsive to first line therapies can necessitate a hysterectomy which would eliminate future fertility. The treatment for intraamniotic infection or hemorrhage related to PPROM is to remove the products of conception from the uterus. It is my opinion these are the types of scenarios where the condition may not meet the "necessary to prevent the death of the pregnant woman" requirement for the affirmative defense under I.C. §18-622 but I would be required under EMTALA to stabilize a condition that without immediate medical attention would place the patient's health in jeopardy.

6. I have read the declarations of Dr. White and Dr. Reynolds. As a maternal-fetal medicine physician I provide direct care for high-risk pregnant patients and also serve as a subspecialist consultant for other medical providers. In my role as a subspecialist physician I am consulted regularly and from around the state of Idaho by a variety of physicians including generalist OB/Gyn, family practice, and emergency medicine for assistance in managing pregnant patients and pregnancy complications. As a subspecialist physician at a tertiary care center who

receives pregnancy related patient transports regularly from around the state, I frequently see conditions that threaten the health of the patient. The three examples in my initial declaration were all cared for within the past year. Even if it is just one patient's health being severely impacted or life lost related to the inability of her medical providers to care for her, that is unacceptable.

7. Dr. Reynolds states that "any effort to redefine abortion to include treatment of ectopic pregnancies is medically baseless and, in my judgment, inexcusable." Idaho Code §18-622 defines an abortion as the termination of a "clinically diagnosable pregnancy". Medically speaking, the healthcare community would not classify treatment of an ectopic pregnancy as an abortion. This statute was not written using medically accepted definitions or terminology. Therefore, providers are left with the plain language of the law and because an ectopic pregnancy is a clinically diagnosable pregnancy this leads to provider fear of prosecution for providing the evidence-based and medically indicated treatment for those patients. Dr. Reynolds, who practices in Nevada, states that Idaho physicians, "may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors" and "[t]he doctor-declarants' comments about 'fears' and 'chillings' of doctors already in Idaho and of Ob-Gyn doctors considering relocating to Idaho do not ring true to me." As a physician who is practicing in Idaho and through my personal interactions with health care providers around the state as well as through my positions with ACOG, the Idaho Perinatal Project advisory board, and the Idaho Coalition for Safe Reproductive Healthcare, provider fear and unease is real and widespread.

8. I have read the declaration of Dr. French who states "the 'life-saving' abortion that results in the death and dismemberment of a fetus in the uterus can cause an entire cascade of reactions that would in fact worsen many of the scenarios that are presented as life-saving." Surgical abortion is a safe treatment. The risk of death associated with childbirth is 14 times higher

than that with abortion. For those complications related directly to the pregnancy itself such as HELLP syndrome, preeclampsia with severe features, severe hemorrhage, and intraamniotic infection, this safe surgical procedure is the definitive treatment that will stop the progression and reduce risks of bodily harm.

9. I have read the declaration of Mr. Loebs. A single prosecutor, from a different jurisdiction from where I practice medicine stating that he would not prosecute a physician based on a few patient examples does not alleviate my fear of criminal prosecution. Similarly, his speculation that all prosecuting attorneys in Idaho would interpret these scenarios the same way he does gives me no security. Implicit in prosecutorial discretion, is the fact that each prosecutor will decide for themselves whether to prosecute these cases, leaving medical providers unable to predict or know how each prosecuting attorney will proceed.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 19th day of August 2022, in Boise, Idaho.

8/19/22
Date

Kylie Cooper
Kylie Cooper MD

EXHIBIT L

IDAHO VITAL STATISTICS

Induced Abortion 2020

Bureau of Vital Records and Health Statistics
Division of Public Health
January 2022

2020 VITAL STATISTICS – INDUCED ABORTION

Contact

For more information on this report or other vital statistics, please contact the Bureau of Vital Records and Health Statistics at (208) 334-6658. This report and other reports from the Bureau of Vital Records and Health Statistics are available on the web at healthandwelfare.idaho.gov. Go to About DHW, select Reports and Statistics, then scroll to Vital Records and Health Statistics and select Idaho Vital Statistics annual reports.

Prepared by

This report was prepared by Pam Harder, Research Analyst Supervisor, of the Idaho Department of Health and Welfare.

Citation

Suggested citation: *Idaho Vital Statistics - Induced Abortion 2020*, Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics, January 2022.

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DEFINITIONS AND FORMULAS

Residence Data

Data allocated by place of residence of the registrant

Induced abortions to Idaho residents include:
1) The number of reported abortions occurring in Idaho to Idaho residents; and,
2) The number of reported abortions occurring in other states to Idaho residents.

Occurrence Data

Data allocated by place where event occurred, regardless of the person's place of residence

Induced abortions occurring in Idaho include:
1) The number of reported abortions occurring in Idaho to Idaho residents; and,
2) The number of reported abortions occurring in Idaho to non-residents.

Induced Abortion

A legal medical procedure that is intended to terminate a pregnancy without a live birth

INDUCED ABORTION RATE -- number of induced abortions per 1,000 females 15-44 years of age

$$\frac{\text{induced abortions}}{\text{females 15-44}} \times 1{,}000$$

INDUCED ABORTION RATIO -- number of induced abortions per 1,000 live births

$$\frac{\text{induced abortions}}{\text{live births}} \times 1{,}000$$

VITAL REGISTRATION AND DATA COLLECTION

Registration of Records

The Idaho Bureau of Vital Records and Health Statistics is responsible for managing Idaho's vital records program and for providing health statistics and analysis. Civil laws of every state provide for a continuous, permanent, and compulsory vital registration system. Idaho is responsible for inspecting each Idaho state record for promptness of filing, completeness, and accuracy of information; querying for missing or inconsistent information; numbering the records; preparing indexes; processing the records; issuing certified copies; and storing the documents for permanent reference and safekeeping.

Induced Abortion

The reporting of induced abortions occurring in Idaho has been required by state statute since July 1, 1977, as provided in Section 39-261, Idaho Code. In 1984, an interstate data exchange program for abortion data was initiated nationwide, whereby Idaho obtains non-identifying information about abortions occurring to Idaho residents in other states. Data in this report are provided for both Idaho resident abortions, regardless of where the procedure occurred, and abortions occurring in Idaho to either Idaho residents or non-residents. The cut-off date for induced abortion records in the data base was November 5, 2021 for 2020 records.

INDUCED ABORTION

U.S.

In 2018, the latest year available, 49 out of 52 reporting areas (50 states, District of Columbia, and New York City) provided data to the Centers for Disease Control and Prevention (CDC) regarding abortions in the United States. A total of 625,346 legal abortions were reported to the CDC by the 49 reporting areas in 2019. In 2019, the U.S. abortion ratio was 195 abortions per 1,000 live births in the reporting area.[1]

	INDUCED ABORTIONS	RATIO PER 1,000 LIVE BIRTHS	RATE PER 1,000 FEMALES AGED 15-44
U.S. 2019[1]	625,346	195	11.4
Idaho 2020 (Occurrence)	1,680	NA	NA
Idaho 2020 (Residence)	2,007	93.2	5.7

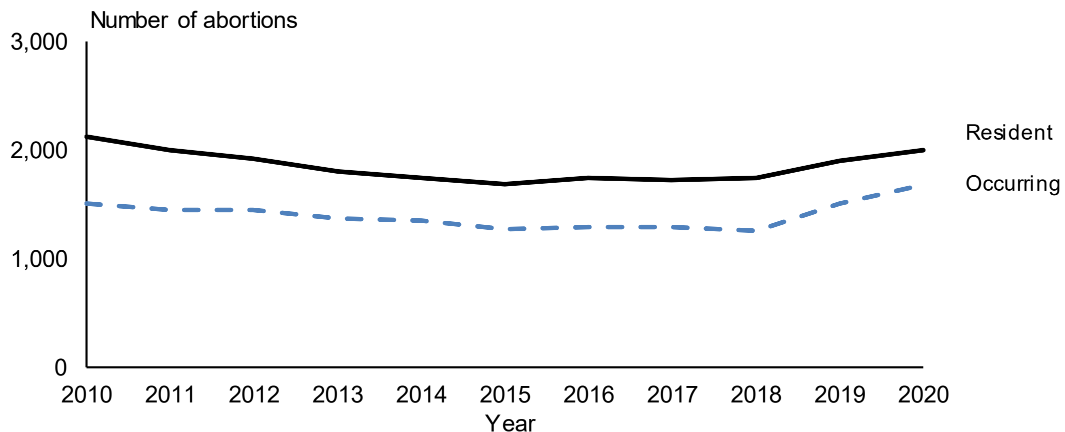
Abortion in Idaho

The reporting of induced abortions occurring in Idaho has been required by state statute since July 1, 1977. The reported numbers increased from 708 during the last half of 1977 to a high of 2,706 in 1981. The number of abortions reported in Idaho in 2020 was 1,680 which was an 11 percent increase from 1,513 reported in Idaho in 2019. Abortions occurring in Idaho may be to Idaho residents or non-residents. Of the 1,680 procedures performed in Idaho, 1,574 (93.7 percent) were to residents of Idaho and 102 (6.1 percent) were to non-residents. There were 4 procedures in Idaho in which the patient's state of residence was not stated (0.2 percent).

Idaho Resident Abortion

Abortions to Idaho residents increased 6.1 percent from 1,882 in 2019 to 2,007 in 2020. Abortions to Idaho residents may occur in Idaho or out of state. In 2020, 1,574 abortions to Idaho residents occurred in Idaho, and 433 were performed out of state. Of the 433 abortions obtained out of state, 359 occurred in Washington, 44 in Utah, 14 in Montana, 15 in Oregon, and 1 in Tennessee.

IDAHO INDUCED ABORTIONS
Idaho Residents and Abortions in Idaho
2010-2020



1. "Abortion Surveillance – United States, 2019", Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Vol 70/No. 9, November 26, 2021.

INDUCED ABORTIONS OCCURRING IN IDAHO
District and County of Occurrence
2010-2020

OCCURRENCE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IN IDAHO	1,510	1,440	1,458	1,375	1,353	1,272	1,289	1,285	1,257	1,513	1,680
District 1	-	-	-	1	-	-	-	-	-	-	-
District 2	-	-	-	-	-	-	-	-	-	-	-
District 3	-	-	-	-	-	-	-	-	-	-	-
District 4	1,370	1,240	1,200	1,106	1,090	1,068	1,047	1,027	1,061	1,261	1,393
District 5	140	199	258	267	263	203	242	258	196	252	287
District 6	-	-	-	-	-	-	-	-	-	-	-
District 7	-	1	-	1	-	1	-	-	-	-	-
Ada	1,370	1,240	1,200	1,106	1,089	1,068	1,047	1,024	1,057	1,252	1,381
Adams	-	-	-	-	-	-	-	-	-	-	-
Bannock	-	-	-	-	-	-	-	-	-	-	-
Bear Lake	-	-	-	-	-	-	-	-	-	-	-
Benewah	-	-	-	-	-	-	-	-	-	-	-
Bingham	-	-	-	-	-	-	-	-	-	-	-
Blaine	-	-	-	-	-	-	-	-	-	-	-
Boise	-	-	-	-	-	-	-	-	-	-	-
Bonner	-	-	-	-	-	-	-	-	-	-	-
Bonneville	-	-	-	-	-	-	-	-	-	-	-
Boundary	-	-	-	-	-	-	-	-	-	-	-
Butte	-	-	-	-	-	-	-	-	-	-	-
Camas	-	-	-	-	-	-	-	-	-	-	-
Canyon	-	-	-	-	-	-	-	-	-	-	-
Caribou	-	-	-	-	-	-	-	-	-	-	-
Cassia	-	-	-	-	-	-	-	-	-	-	-
Clark	-	-	-	-	-	-	-	-	-	-	-
Clearwater	-	-	-	-	-	-	-	-	-	-	-
Custer	-	-	-	-	-	-	-	-	-	-	-
Elmore	-	-	-	-	-	-	-	-	-	-	-
Franklin	-	-	-	-	-	-	-	-	-	-	-
Fremont	-	-	-	-	-	-	-	-	-	-	-
Gem	-	-	-	-	-	-	-	-	-	-	-
Gooding	-	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	-
Jefferson	-	-	-	-	-	-	-	-	-	-	-
Jerome	-	-	-	-	-	-	-	-	-	-	-
Kootenai	-	-	-	1	-	-	-	-	-	-	-
Latah	-	-	-	-	-	-	-	-	-	-	-
Lemhi	-	-	-	-	-	-	-	-	-	-	-
Lewis	-	-	-	-	-	-	-	-	-	-	-
Lincoln	-	-	-	-	-	-	-	-	-	-	-
Madison	-	1	-	1	-	1	-	-	-	-	-
Minidoka	-	-	-	-	-	-	-	-	-	-	-
Nez Perce	-	-	-	-	-	-	-	-	-	-	-
Oneida	-	-	-	-	-	-	-	-	-	-	-
Owyhee	-	-	-	-	-	-	-	-	-	-	-
Payette	-	-	-	-	-	-	-	-	-	-	-
Power	-	-	-	-	-	-	-	-	-	-	-
Shoshone	-	-	-	-	-	-	-	-	-	-	-
Teton	-	-	-	-	-	-	-	-	-	-	-
Twin Falls	140	199	258	267	263	203	242	258	196	252	287
Valley	-	-	-	-	1	-	-	3	4	9	12
Washington	-	-	-	-	-	-	-	-	-	-	-

INDUCED ABORTIONS OCCURRING IN IDAHO
District and County of Occurrence by Place of Residence
2020

OCCURRENCE	ABORTIONS OCCURRING IN IDAHO		
	Abortion in Idaho, District and County of Occurrence, Total	Resident of Idaho	Resident of Other State or Unknown
IDAHO	1,680	1,574	106
District 1	-	-	-
District 2	-	-	-
District 3	-	-	-
District 4	1,393	1,319	74
District 5	287	255	32
District 6	-	-	-
District 7	-	-	-
Ada	1,381	1,307	74
Adams	-	-	-
Bannock	-	-	-
Bear Lake	-	-	-
Benewah	-	-	-
Bingham	-	-	-
Blaine	-	-	-
Boise	-	-	-
Bonner	-	-	-
Bonneville	-	-	-
Boundary	-	-	-
Butte	-	-	-
Camas	-	-	-
Canyon	-	-	-
Caribou	-	-	-
Cassia	-	-	-
Clark	-	-	-
Clearwater	-	-	-
Custer	-	-	-
Elmore	-	-	-
Franklin	-	-	-
Fremont	-	-	-
Gem	-	-	-
Gooding	-	-	-
Idaho	-	-	-
Jefferson	-	-	-
Jerome	-	-	-
Kootenai	-	-	-
Latah	-	-	-
Lemhi	-	-	-
Lewis	-	-	-
Lincoln	-	-	-
Madison	-	-	-
Minidoka	-	-	-
Nez Perce	-	-	-
Oneida	-	-	-
Owyhee	-	-	-
Payette	-	-	-
Power	-	-	-
Shoshone	-	-	-
Teton	-	-	-
Twin Falls	287	255	32
Valley	12	12	-
Washington	-	-	-

INDUCED ABORTIONS OCCURRING IN IDAHO
Selected Demographic Characteristics
2010-2020

DEMOGRAPHIC CHARACTERISTICS	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IN IDAHO	1,510	1,440	1,458	1,375	1,353	1,272	1,289	1,285	1,257	1,513	1,680
Age:											
10-14	6	6	3	3	7	2	3	1	4	2	9
15-19	246	207	235	173	175	165	164	146	138	187	195
15-17	75	54	68	45	39	48	40	38	34	33	44
18-19	171	153	167	128	136	117	124	108	104	154	151
20-24	509	475	484	492	462	433	436	426	411	477	546
25-29	335	329	353	340	339	274	328	305	329	378	423
30-34	251	252	212	177	201	202	211	216	200	252	279
35-39	121	115	106	135	124	144	102	144	140	161	174
40-44	40	53	59	50	42	45	41	42	30	49	48
45+	2	2	5	5	3	7	3	5	4	6	6
Not stated	-	1	1	-	-	-	1	-	1	1	0
Idaho residence status:											
Resident	1,435	1,372	1,379	1,321	1,283	1,213	1,244	1,235	1,209	1,429	1,574
Non-resident	75	68	79	54	70	59	45	50	48	78	102
Not stated										6	4
Marital status:											
Married	227	226	197	225	223	231	228	227	229	302	349
Not married	1,283	1,209	1,257	1,143	1,103	997	965	909	874	1,094	1,258
Not stated	-	5	4	7	27	44	96	149	154	117	73
Previous induced abortions:											
None	1,055	1,007	1,049	1,014	937	932	933	958	956	1,228	1,339
1	331	317	251	251	292	252	252	217	201	209	250
2	85	75	69	64	87	59	79	69	64	44	66
3+	39	32	28	28	36	26	23	34	24	21	24
Not stated	-	9	61	18	1	3	2	7	12	11	1
Race											
White	1,315	1,244	1,260	1,178	1,150	1,041	1,054	998	1,048	1,199	1,447
Black	22	16	23	20	22	28	26	30	38	42	42
American Indian	24	9	12	22	15	11	24	20	18	28	24
Asian/Pacific Islander	45	42	45	38	41	27	44	42	30	40	45
Other	32	39	60	78	51	57	76	59	21	23	17
Race not stated	72	90	58	39	74	108	65	136	102	181	105
Ethnicity*											
Hispanic	246	195	222	202	209	184	245	252	235	346	369
Non-Hispanic	1,242	1,230	1,218	1,135	1,107	984	989	934	990	1,112	1,258
Ethnicity not stated	22	15	18	38	37	104	55	99	32	55	53

*Race and Hispanic origin are reported separately on the abortion report. Women of Hispanic origin are included in appropriate race totals

INDUCED ABORTIONS OCCURRING IN IDAHO
Selected Demographic Characteristics (Percent)
2010-2020

DEMOGRAPHIC CHARACTERISTICS	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IN IDAHO	1,510	1,440	1,458	1,375	1,353	1,272	1,289	1,285	1,257	1,513	1,680
Age:											
10-14	0.4%	0.4%	0.2%	0.2%	0.5%	0.2%	0.2%	0.1%	0.3%	0.1%	0.5%
15-19	16.3	14.4	16.1	12.6	12.9	13.0	12.7	11.4	11.0	12.4	11.6
15-17	5.0	3.8	4.7	3.3	2.9	3.8	3.1	3.0	2.7	2.2	2.6
18-19	11.3	10.6	11.5	9.3	10.1	9.2	9.6	8.4	8.3	10.2	9.0
20-24	33.7	33.0	33.2	35.8	34.1	34.0	33.9	33.2	32.7	31.5	32.5
25-29	22.2	22.9	24.2	24.7	25.1	21.5	25.5	23.7	26.2	25.0	25.2
30-34	16.6	17.5	14.6	12.9	14.9	15.9	16.4	16.8	15.9	16.7	16.6
35-39	8.0	8.0	7.3	9.8	9.2	11.3	7.9	11.2	11.1	10.6	10.4
40-44	2.6	3.7	4.0	3.6	3.1	3.5	3.2	3.3	2.4	3.2	2.9
45+	0.1	0.1	0.3	0.4	0.2	0.6	0.2	0.4	0.3	0.4	0.4
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Idaho residence status:											
Resident	95.0%	95.3%	94.6%	96.1%	94.8%	95.4%	96.5%	96.1%	96.2%	94.4%	93.7%
Non-resident	5.0	4.7	5.4	3.9	5.2	4.6	3.5	3.9	3.8	5.2	6.3
Not stated										NA	NA
Marital status:											
Married	15.0%	15.7%	13.5%	16.4%	16.8%	18.8%	19.1%	20.0%	20.8%	21.6%	21.7%
Not married	85.0	84.3	86.5	83.6	83.2	81.2	80.9	80.0	79.2	78.4%	78.3
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Previous induced abortions:											
None	69.9%	70.4%	75.1%	74.7%	69.3%	73.4%	72.5%	75.0%	76.8%	81.8%	79.7%
1	21.9	22.2	18.0	18.5	21.6	19.9	19.6	17.0	16.1	13.9	14.9
2	5.6	5.2	4.9	4.7	6.4	4.6	6.1	5.4	5.1	2.9	3.9
3+	2.6	2.2	2.0	2.1	2.7	2.0	1.8	2.7	1.9	1.4	1.4
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Race											
White	91.4%	92.1%	90.0%	88.2%	89.9%	89.4%	86.1%	86.9%	90.7%	90.0%	91.9%
Black	1.5	1.2	1.6	1.5	1.7	2.4	2.1	2.6	3.3	3.2	2.7
American Indian	1.7	0.7	0.9	1.6	1.2	0.9	2.0	1.7	1.6	2.1	1.5
Asian/Pacific Islander	3.1	3.1	3.2	2.8	3.2	2.3	3.6	3.7	2.6	3.0	2.9
Other	2.2	2.9	4.3	5.8	4.0	4.9	6.2	5.1	1.8	1.7	1.1
Race not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Ethnicity*											
Hispanic	16.5%	13.7%	15.4%	15.1%	15.9%	15.8%	19.9%	21.2%	19.2%	23.7%	22.7%
Non-Hispanic	83.5	86.3	84.6	84.9	84.1	84.2	80.1	78.8	80.8	76.3	77.3
Ethnicity not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Race and Hispanic origin are reported separately on the abortion report. Women of Hispanic origin are included in appropriate race total
NA - not applicable.
Percent distributions are based on records with known data. Percentages may not sum to 100 due to rounding.

INDUCED ABORTIONS OCCURRING IN IDAHO
Clinical Estimated Weeks of Gestation and Primary Termination Procedure
2010-2020

PROCEDURE CHARACTERISTICS	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IN IDAHO	1,510	1,440	1,458	1,375	1,353	1,272	1,289	1,285	1,257	1,513	1,680
Weeks of gestation											
Number[1]											
<9	994	887	978	921	923	832	824	823	817	1,049	1,167
9-10	282	300	242	234	238	248	257	252	222	223	257
11-12	163	174	141	144	115	104	108	112	124	121	101
13-15	59	69	86	64	67	80	97	89	84	101	125
16-20	6	6	10	9	6	8	1	4	8	4	21
21-24	5	2	1	3	1	-	-	1	-	2	4
25+	1	-	-	-	-	-	1	-	-	-	-
Not stated	-	2	-	-	3	-	1	4	2	13	5
Percent[1]											
<9	65.8%	61.7%	67.1%	67.0%	68.4%	65.4%	64.0%	64.2%	65.1%	69.9%	69.7%
9-10	18.7	20.9	16.6	17.0	17.6	19.5	20.0	19.7	17.7	14.9	15.3
11-12	10.8	12.1	9.7	10.5	8.5	8.2	8.4	8.7	9.9	8.1	6.0
13-15	3.9	4.8	5.9	4.7	5.0	6.3	7.5	6.9	6.7	6.7	7.5
16-20	0.4	0.4	0.7	0.7	0.4	0.6	0.1	0.3	0.6	0.3	1.3
21-24	0.3	0.1	0.1	0.2	0.1	-	-	0.1	-	0.1	0.2
25+	0.1	-	-	-	-	-	0.1	-	-	-	-
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Termination procedure											
Number[2]											
Suction curettage	995	932	883	845	778	666	622	685	682	772	705
Sharp curettage (D&C)	2	2	2	3	1	-	-	-	-	4	2
Dilation and evacuation (D&E)	6	4	12	8	24	45	85	44	57	102	80
Intra-uterine instillation (saline or prostaglandin)	1	1	2	2	2	-	-	-	-	1	2
Medical (nonsurgical)	504	499	559	513	547	561	581	556	515	632	889
Hysterotomy/Hysterectomy	-	-	-	-	-	-	-	-	-	-	-
Other	2	2	-	4	1	-	1	-	-	2	1
Not stated	-	-	-	-	-	-	-	-	3	-	1
Percent[2]											
Suction curettage	65.9%	64.7%	60.6%	61.5%	57.5%	52.4%	48.3%	53.3%	54.4%	51.0%	42.0%
Sharp curettage (D&C)	0.1	0.1	0.1	0.2	0.1	-	-	-	-	0.3	0.1
Dilation and evacuation (D&E)	0.4	0.3	0.8	0.6	1.8	3.5	6.6	3.4	4.5	6.7	4.8
Intra-uterine instillation (saline or prostaglandin)	0.1	0.1	0.1	0.1	0.1	-	-	-	-	0.1	0.1
Medical (nonsurgical)	33.4	34.7	38.3	37.3	40.4	44.1	45.1	43.3	41.1	41.8	52.9
Hysterotomy/Hysterectomy	-	-	-	-	-	-	-	-	-	-	-
Other	0.1	0.1	-	0.3	0.1	-	0.1	-	-	0.1	0.1
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

1. The clinical estimated length of gestation may differ from length of gestation based on the date of last normal menses and date of pregnancy termination. Data based on week's of gestation differ from data based on week's Postfertilization. The Postfertilization age is the age as calculated from the fertilization of the human ovum. Fertilization of the human ovum occurs approximately two weeks after the onset of menses. The clinical estimated length of gestation is approximately two weeks longer than the number of week's Postfertilization.

2. The primary procedure that terminated the pregnancy is shown; there may be additional procedures used for the termination.

NA: not applicable.

INDUCED ABORTIONS OCCURRING IN IDAHO
Age of Patient by Length of Gestation[1]
2020

AGE OF PATIENT	TOTAL IN IDAHO	WEEKS OF GESTATION							
		<9	9-10	11-12	13-15	16-20	21-24	25+	Not Stated
TOTAL	1,680	1,167	257	101	125	21	4	-	5
<15	9	3	4	1	-	1	-	-	-
15-19	195	118	38	14	20	3	-	-	2
15-17	44	25	8	4	5	1	-	-	1
18-19	151	93	30	10	15	2	-	-	1
20-24	546	390	85	32	32	5	1	-	1
25-29	423	285	76	26	30	5	-	-	1
30-34	279	211	30	13	19	3	3	-	-
35-39	174	128	15	11	17	2	-	-	1
40-44	48	28	8	3	7	2	-	-	-
45+	6	4	1	1	-	-	-	-	-
Not stated	-	-	-	-	-	-	-	-	-

1. Length of gestation is based on the clinical estimate of gestation in completed weeks. Data by clinical estimate of gestation may differ from length of gestation based on date last normal menses began and date of pregnancy termination.

INDUCED ABORTIONS OCCURRING IN IDAHO
Age of Patient by Number of Previous Induced Abortions and Live Births
2020

AGE OF PATIENT	TOTAL IN IDAHO	NUMBER OF PREVIOUS ABORTIONS				NUMBER OF PREVIOUS LIVE BIRTHS			
		None	1	2+	Not Stated	None	1	2+	Not Stated
TOTAL	1,680	1,339	250	90	1	857	327	496	-
<15	9	9	-	-	-	9	-	-	-
15-19	195	183	11	1	-	175	19	1	-
15-17	44	42	2	-	-	41	3	-	-
18-19	151	141	9	1	-	134	16	1	-
20-24	546	457	72	17	-	353	117	76	-
25-29	423	321	76	26	-	183	88	152	-
30-34	279	215	45	19	-	97	58	124	-
35-39	174	114	38	22	-	33	36	105	-
40-44	48	35	7	5	1	7	9	32	-
45+	6	5	1	-	-	-	-	6	-
Not stated	-	-	-	-	-	-	-	-	-

INDUCED ABORTIONS OCCURRING IN IDAHO
Primary Termination Procedure[1] by Length of Gestation[2]
2020

TERMINATION PROCEDURE[1]	TOTAL IN IDAHO	WEEKS OF GESTATION							
		<9	9-10	11-12	13-15	16-20	21-24	25+	Not Stated
TOTAL IN IDAHO	1,680	1,167	257	101	125	21	4	-	5
Suction curettage	705	410	127	89	72	4	-	-	3
Sharp curettage	2	2	-	-	-	-	-	-	-
Dilation and evacuation (D&E)	80	-	2	10	48	16	3	-	1
Intra-uterine saline/ prostaglandin instillation	2	-	1	-	1	-	-	-	-
Hysterotomy/hysterectomy	-	-	-	-	-	-	-	-	-
Medical (non-surgical)	889	754	127	2	3	1	1	-	1
Other	1	1	-	-	-	-	-	-	-
Not stated	1	-	-	-	1	-	-	-	-

1. Primary termination procedure reported; there may be more than one procedure reported.
2. Length of gestation is based on the clinical estimate of gestation in completed weeks. Data by clinical estimate of gestation may differ from length of gestation based on date last normal menses began and date of pregnancy termination.

INDUCED ABORTIONS OCCURRING IN IDAHO
Age of Patient by Marital Status
2020

AGE OF PATIENT	TOTAL IN IDAHO	MARITAL STATUS		
		Married	Not Married	Not Stated
TOTAL	1,680	349	1,258	73
<15	9	-	8	1
15-19	195	5	186	4
15-17	44	-	44	-
18-19	151	5	142	4
20-24	546	50	474	22
25-29	423	90	308	25
30-34	279	104	163	12
35-39	174	75	92	7
40-44	48	21	25	2
45+	6	4	2	-
Not stated	-	-	-	-

INDUCED ABORTIONS OCCURRING IN IDAHO
Number of Previous Induced Abortions and Living Children
and Percentage of Abortions
By Number of Previous Induced Abortions or Living Children
2020

	PREVIOUS INDUCED ABORTIONS		LIVING CHILDREN	
	Number	Percent	Number	Percent
TOTAL	1,680	100.0%	1,680	100.0%
None	1,339	79.7%	857	51.0%
1	250	14.9	327	19.5
2	66	3.9	280	16.7
3+	24	1.4	216	12.9
Not stated	1	NA	-	NA

Percentages are based on records with stated number of previous induced abortions or number of living children.

INDUCED ABORTIONS OCCURRING IN IDAHO
Patient Educational Materials Provided
2010-2020

YEAR	WERE PATIENT EDUCATIONAL MATERIALS PROVIDED?			
	Yes	No	Unknown	Total
2010	1,509	1	-	1,510
2011	1,440	-	-	1,440
2012	1,458	-	-	1,458
2013	1,375	-	-	1,375
2014	1,351	-	2	1,353
2015	1,271	1	-	1,272
2016	1,285	1	3	1,289
2017	1,284	1	-	1,285
2018	1,254	-	3	1,257
2019	1,510	-	3	1,513
2020	1,677	-	3	1,680

Note: prior to July 1, 2006, any educational material may have been provided to patient. Starting July 1, 2006, educational materials from the Idaho Department of Health and Welfare must be provided to patient by law. It is possible to have reports of procedures with unknown or no patient educational materials provided in rare cases of medical emergencies.

INDUCED ABORTIONS OCCURRING IN IDAHO
Informed Consent, Aged Under 18*
2020

Total Abortions Aged <18	53
TERMINATION PERFORMED FOLLOWING:	
Written informed consent of a parent, guardian, or conservator and the minor	50
Written informed consent of emancipated minor for herself	1
Written informed consent of minor for herself pursuant to court order granting minor right to self-consent	2
Written informed consent of court pursuant to order stating abortion in best interest of minor, despite absence of parental consent	-
Certification from minor that pregnancy resulted from rape or sexual conduct with minor by minor's parent, stepparent, uncle, grandparent, sibling, adoptive parent, legal guardian, or foster parent	-
Medical emergency	-
Unknown	-

*Informed consent for one procedure to a female under 18 was updated in January 2022 from unknown to written informed consent of a parent, guardian, or conservator and the minor.

INDUCED ABORTIONS TO IDAHO RESIDENTS
Number by District and County of Residence
2010-2020

RESIDENCE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020*
TOTAL*	2,123	2,005	1,916	1,794	1,751	1,686	1,749	1,730	1,742	1,892	2,007
District 1	333	268	264	229	242	252	226	241	279	233	255
District 2	126	160	90	102	109	106	95	115	118	113	90
District 3	326	312	319	305	276	270	276	284	290	319	379
District 4	851	794	794	718	692	689	702	665	684	767	822
District 5	226	222	230	218	254	188	211	216	201	263	253
District 6	152	153	132	128	98	101	144	117	85	97	103
District 7	109	96	87	94	80	80	95	92	85	100	103
Ada	786	735	729	668	649	640	656	603	636	720	776
Adams	-	2	3	4	2	5	3	3	3	2	2
Bannock	111	88	84	81	63	72	101	79	54	66	65
Bear Lake	3	2	1	3	-	-	1	2	1	-	-
Benewah	11	12	4	6	4	5	7	3	10	6	7
Bingham	25	46	33	31	22	15	22	22	17	20	26
Blaine	39	42	41	34	56	33	32	39	26	45	32
Boise	9	8	2	8	8	5	8	3	3	3	1
Bonner	55	38	40	33	29	32	40	34	45	39	47
Bonneville	75	65	60	68	59	58	67	60	61	63	68
Boundary	7	6	5	8	5	5	4	3	7	7	6
Butte	-	1	1	1	3	1	1	1	1	1	2
Camas	-	2	-	1	-	1	1	-	-	-	-
Canyon	264	271	264	253	234	217	230	232	236	266	319
Caribou	3	3	1	3	1	3	2	1	1	3	1
Cassia	18	17	14	16	23	10	13	13	19	22	35
Clark	-	-	-	-	-	-	1	1	1	-	2
Clearwater	4	7	3	6	5	7	3	4	10	5	3
Custer	3	1	2	5	2	4	4	1	2	4	-
Elmore	43	39	45	31	25	35	30	47	41	29	31
Franklin	4	1	6	4	3	2	6	6	5	3	7
Fremont	1	5	2	5	4	2	1	6	3	5	4
Gem	13	9	13	12	9	15	13	14	14	13	13
Gooding	23	13	8	10	12	9	9	15	12	22	15
Idaho	8	8	6	4	5	6	7	6	6	5	6
Jefferson	12	8	6	9	7	3	9	11	4	9	11
Jerome	15	26	24	21	28	21	22	17	21	30	34
Kootenai	248	192	195	163	184	197	166	190	206	171	183
Latah	59	64	43	57	54	50	38	52	53	48	39
Lemhi	5	5	11	2	3	2	3	6	5	6	4
Lewis	2	3	1	-	2	4	5	1	5	4	2
Lincoln	6	4	8	2	4	4	6	3	2	3	7
Madison	3	6	5	5	2	6	5	5	7	11	13
Minidoka	20	13	21	24	15	7	21	17	18	22	18
Nez Perce	53	78	37	35	43	39	42	52	44	51	40
Oneida	1	2	2	1	1	-	2	1	2	2	-
Owyhee	12	7	7	4	8	3	3	5	10	10	8
Payette	31	18	26	22	20	24	18	21	20	18	27
Power	5	10	4	4	5	8	9	5	4	2	2
Shoshone	12	20	20	19	20	13	9	11	11	10	12
Teton	10	6	1	-	3	5	5	2	2	2	1
Twin Falls	105	105	114	110	116	103	107	112	103	119	112
Valley	13	12	18	11	10	9	8	12	4	15	14
Washington	6	5	6	10	3	6	9	9	7	10	10

*Total in 2020 includes 2 abortions in which county and district of residence was unknown.

INDUCED ABORTIONS TO IDAHO RESIDENTS
Abortion Rate by District and County of Residence
2010-2020

RESIDENCE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	6.9	6.5	6.2	5.8	5.6	5.3	5.4	5.3	5.2	5.5	5.7
District 1	8.9	7.2	7.0	6.1	6.4	6.6	5.7	6.0	6.8	5.6	5.9
District 2	6.3	7.9	4.4	5.0	5.4	5.2	4.7	5.6	5.7	5.4	4.3
District 3	6.6	6.3	6.4	6.0	5.3	5.1	5.2	5.2	5.2	5.5	6.3
District 4	9.6	8.9	8.7	7.8	7.4	7.3	7.3	6.7	6.7	7.3	7.6
District 5	6.6	6.5	6.7	6.3	7.2	5.3	5.9	5.9	5.4	7.0	6.6
District 6	4.6	4.6	4.0	3.9	3.0	3.1	4.4	3.5	2.5	2.8	2.9
District 7	2.5	2.2	2.0	2.2	1.8	1.8	2.1	2.0	1.8	2.1	2.1
Ada	9.7	9.0	8.7	7.9	7.6	7.3	7.4	6.6	6.7	7.4	7.8
Adams	-	3.8	6.0	8.2	4.1	10.5	6.4	5.9	5.8	3.8	3.7
Bannock	6.4	4.9	4.7	4.6	3.6	4.1	5.8	4.5	3.0	3.6	3.5
Bear Lake	3.2	2.1	1.0	3.1	-	-	1.0	2.0	1.0	-	-
Benewah	7.7	8.8	2.9	4.5	3.0	3.7	5.3	2.2	7.4	4.4	5.0
Bingham	2.9	5.3	3.9	3.7	2.6	1.8	2.6	2.6	1.9	2.2	2.9
Blaine	10.5	11.5	11.5	9.6	15.5	9.3	8.9	11.0	7.1	11.8	8.2
Boise	9.8	8.6	2.2	8.9	8.8	5.1	8.3	3.1	2.9	2.8	0.9
Bonner	8.8	6.1	6.5	5.3	4.6	5.1	6.2	5.2	6.7	5.7	6.8
Bonneville	3.7	3.2	2.9	3.2	2.8	2.7	3.0	2.6	2.6	2.6	2.8
Boundary	4.1	3.6	3.0	4.8	2.9	2.8	2.1	1.6	3.8	3.7	3.1
Butte	-	2.4	2.5	2.6	7.4	2.5	2.6	2.7	2.6	2.5	4.8
Camas	-	10.8	-	6.0	-	5.9	6.1	-	-	-	-
Canyon	6.8	7.0	6.7	6.3	5.7	5.2	5.4	5.3	5.2	5.7	6.6
Caribou	2.7	2.7	0.9	2.7	0.9	2.7	1.8	0.9	0.8	2.4	0.8
Cassia	4.3	4.1	3.4	3.8	5.4	2.3	3.0	3.0	4.3	4.9	7.7
Clark	-	-	-	-	-	-	6.3	6.2	5.8	-	12.3
Clearwater	3.6	6.6	2.9	5.9	5.1	7.0	3.0	3.9	9.4	4.7	2.7
Custer	4.9	1.7	3.3	8.2	3.4	7.1	7.2	1.8	3.6	7.0	-
Elmore	7.7	7.2	8.4	5.9	4.8	6.9	5.9	9.0	7.7	5.5	5.8
Franklin	1.7	0.4	2.6	1.7	1.3	0.8	2.4	2.4	1.9	1.2	2.6
Fremont	0.4	2.2	0.9	2.2	1.8	0.9	0.5	2.6	1.3	2.2	1.7
Gem	4.8	3.4	5.0	4.6	3.5	5.8	4.8	5.1	4.9	4.5	4.3
Gooding	8.5	4.9	3.1	3.9	4.6	3.4	3.4	5.9	4.7	8.4	5.5
Idaho	3.7	3.7	2.8	1.9	2.4	2.9	3.3	2.9	2.9	2.4	2.8
Jefferson	2.4	1.6	1.2	1.8	1.4	0.6	1.7	2.0	0.7	1.6	1.9
Jerome	3.5	6.1	5.7	5.0	6.6	5.0	5.2	3.9	4.7	6.6	7.4
Kootenai	9.6	7.4	7.4	6.2	6.9	7.2	6.0	6.7	7.1	5.7	5.9
Latah	6.5	6.9	4.6	6.1	5.8	5.3	4.0	5.5	5.4	4.9	3.9
Lemhi	4.7	4.7	10.8	2.0	3.0	1.9	2.9	5.6	4.6	5.4	3.6
Lewis	3.9	5.7	1.9	-	3.9	7.7	9.4	1.9	9.5	7.2	3.6
Lincoln	6.2	4.2	8.2	2.0	4.0	3.9	5.9	2.9	2.0	2.9	6.8
Madison	0.3	0.5	0.4	0.5	0.2	0.5	0.5	0.5	0.6	1.0	1.1
Minidoka	5.8	3.7	6.0	6.7	4.2	1.9	5.7	4.6	4.8	5.8	4.6
Nez Perce	7.4	10.9	5.1	4.8	5.9	5.4	5.7	7.1	6.0	6.9	5.4
Oneida	1.5	3.1	3.1	1.5	1.5	-	2.9	1.4	2.8	2.8	-
Owyhee	6.0	3.5	3.5	2.0	4.1	1.5	1.5	2.5	5.0	4.9	3.7
Payette	7.5	4.4	6.4	5.5	5.0	6.0	4.5	5.2	4.9	4.3	6.3
Power	3.6	7.4	2.9	3.0	3.8	6.1	6.8	3.9	3.0	1.5	1.5
Shoshone	6.1	10.2	10.1	9.6	10.6	7.0	4.9	5.8	5.6	5.1	6.2
Teton	4.6	2.9	0.5	-	1.5	2.4	2.3	0.9	0.9	0.9	0.4
Twin Falls	7.1	7.0	7.5	7.1	7.4	6.4	6.6	6.7	6.1	6.9	6.4
Valley	8.9	8.5	12.7	7.9	7.1	6.2	5.4	7.9	2.5	9.0	7.9
Washington	3.8	3.2	3.8	6.5	1.9	4.0	6.0	6.0	4.6	6.6	6.4

Abortion rate: Number of induced abortions to women of all ages per 1,000 females 15-44 years of age. Some rates are based on small numbers (<20), and caution is advised when interpreting rates based on small numbers.

INDUCED ABORTIONS TO IDAHO RESIDENTS
District and County of Residence by State of Occurrence
2020

RESIDENCE	ABORTIONS OCCURRING TO IDAHO RESIDENTS		
	Total*	Abortion Occurring in Idaho	Abortion Occurring in Other State
IDAHO	2,007	1,574	433
District 1	255	1	254
District 2	90	2	88
District 3	379	368	11
District 4	822	799	23
District 5	253	249	4
District 6	103	86	17
District 7	103	68	35
Ada	776	753	23
Adams	2	2	-
Bannock	65	57	8
Bear Lake	-	-	-
Benewah	7	-	7
Bingham	26	23	3
Blaine	32	32	-
Boise	1	1	-
Bonner	47	-	47
Bonneville	68	50	18
Boundary	6	-	6
Butte	2	2	-
Camas	-	-	-
Canyon	319	310	9
Caribou	1	1	-
Cassia	35	34	1
Clark	2	1	1
Clearwater	3	1	2
Custer	-	-	-
Elmore	31	31	-
Franklin	7	1	6
Fremont	4	2	2
Gem	13	13	-
Gooding	15	15	-
Idaho	6	-	6
Jefferson	11	6	5
Jerome	34	33	1
Kootenai	183	1	182
Latah	39	-	39
Lemhi	4	-	4
Lewis	2	1	1
Lincoln	7	7	-
Madison	13	9	4
Minidoka	18	18	-
Nez Perce	40	-	40
Oneida	-	-	-
Owyhee	8	8	-
Payette	27	26	1
Power	2	2	-
Shoshone	12	-	12
Teton	1	-	1
Twin Falls	112	110	2
Valley	14	14	-
Washington	10	9	1

*Total in 2020 includes 2 abortions in which county and district of residence was unknown (one procedure in Idaho and one procedure out of state).

INDUCED ABORTIONS TO IDAHO RESIDENTS
Rates by District and County of Residence
Age of Patient
2020

	TOTAL		AGE OF PATIENT									
				15-19								
RESIDENCE	Number	Rate[1]	<15	Total	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45+
IDAHO*	2,007	5.7	9	238	56	182	644	499	350	198	61	8
District 1	255	5.9	1	28	8	20	70	71	52	22	10	1
District 2	90	4.3	-	9	1	8	41	16	14	5	4	1
District 3	379	6.3	3	49	12	37	132	98	53	36	7	1
District 4	822	7.6	2	79	16	63	255	206	157	93	28	2
District 5	253	6.6	2	39	9	30	80	59	40	23	7	3
District 6	103	2.9	-	10	3	7	33	28	22	7	3	-
District 7	103	2.1	1	23	7	16	32	21	12	12	2	-
Ada	776	7.8	2	76	15	61	242	192	147	87	28	2
Adams	2	3.7	-	1	1	-	-	-	1	-	-	-
Bannock	65	3.5	-	7	3	4	24	14	13	5	2	-
Bear Lake	-	-	-	-	-	-	-	-	-	-	-	-
Benewah	7	5.0	-	1	1	-	1	2	3	-	-	-
Bingham	26	2.9	-	2	-	2	7	9	7	1	-	-
Blaine	32	8.2	-	4	1	3	6	8	9	4	1	-
Boise	1	0.9	-	-	-	-	-	1	-	-	-	-
Bonner	47	6.8	1	2	1	1	17	12	7	4	3	1
Bonneville	68	2.8	-	13	4	9	19	18	7	9	2	-
Boundary	6	3.1	-	-	-	-	4	-	1	1	-	-
Butte	2	4.8	-	-	-	-	-	2	-	-	-	-
Camas	-	-	-	-	-	-	-	-	-	-	-	-
Canyon	319	6.6	3	36	8	28	113	89	38	32	7	1
Caribou	1	0.8	-	-	-	-	-	-	1	-	-	-
Cassia	35	7.7	-	6	2	4	12	7	6	3	-	1
Clark	2	12.3	-	1	-	1	1	-	-	-	-	-
Clearwater	3	2.7	-	-	-	-	1	1	-	-	1	-
Custer	-	-	-	-	-	-	-	-	-	-	-	-
Elmore	31	5.8	-	1	-	1	10	11	6	3	-	-
Franklin	7	2.6	-	1	-	1	2	1	1	1	1	-
Fremont	4	1.7	-	-	-	-	2	-	2	-	-	-
Gem	13	4.3	-	5	2	3	4	2	1	1	-	-
Gooding	15	5.5	-	2	1	1	1	4	4	4	-	-
Idaho	6	2.8	-	2	-	2	2	-	2	-	-	-
Jefferson	11	1.9	-	3	2	1	5	1	1	1	-	-
Jerome	34	7.4	1	7	2	5	13	7	3	1	1	1
Kootenai	183	5.9	-	24	5	19	44	53	40	17	5	-
Latah	39	3.9	-	3	1	2	21	7	4	3	-	1
Lemhi	4	3.6	-	1	-	1	1	1	1	-	-	-
Lewis	2	3.6	-	-	-	-	1	1	-	-	-	-
Lincoln	7	6.8	-	-	-	-	4	2	-	1	-	-
Madison	13	1.1	1	5	1	4	4	1	1	1	-	-
Minidoka	18	4.6	-	6	2	4	6	4	2	-	-	-
Nez Perce	40	5.4	-	4	-	4	16	7	8	2	3	-
Oneida	-	-	-	-	-	-	-	-	-	-	-	-
Owyhee	8	3.7	-	3	1	2	4	-	1	-	-	-
Payette	27	6.3	-	3	-	3	7	6	10	1	-	-
Power	2	1.5	-	-	-	-	-	2	-	-	-	-
Shoshone	12	6.2	-	1	1	-	4	4	1	-	2	-
Teton	1	0.4	-	-	-	-	-	-	-	1	-	-
Twin Falls	112	6.4	1	14	1	13	38	27	16	10	5	1
Valley	14	7.9	-	2	1	1	3	2	4	3	-	-
Washington	10	6.4	-	1	-	1	4	1	2	2	-	-

1. Abortion rate: Number of induced abortions per 1,000 women 15-44 years of age.
*Total in 2020 includes 2 abortions in which county and district of residence was unknown (one age group 18-19 and one age group 20-24).

INDUCED ABORTIONS TO IDAHO RESIDENTS
Ratios and Race/Ethnicity of Patient by District and County of Residence
2020

RESIDENCE	TOTAL ABORTIONS		RACE						ETHNICITY[2]		
	Number	Ratio[1]	White	Black	American Indian	Asian/ Pacific Islander	Other Race	Race Not Stated	Non-Hispanic	Hispanic	Ethnicity Not Stated
IDAHO*	2,007	93.2	1,720	49	31	48	21	138	1,230	355	422
District 1	255	96.9	234	2	4	1	1	13	6	-	249
District 2	90	81.6	66	1	4	3	1	15	2	-	88
District 3	379	94.7	330	3	5	7	5	29	254	105	20
District 4	822	151.5	693	33	9	31	4	52	677	96	49
District 5	253	101.6	226	5	1	1	3	17	146	102	5
District 6	103	46.7	84	2	5	2	4	6	78	20	5
District 7	103	28.0	85	3	3	3	3	6	66	32	5
Ada	776	159.1	654	32	9	30	4	47	641	89	46
Adams	2	51.3	2	-	-	-	-	-	2	-	-
Bannock	65	62.0	55	1	2	2	2	3	56	6	3
Bear Lake	-	-	-	-	-	-	-	-	-	-	-
Benewah	7	65.4	6	-	1	-	-	-	-	-	7
Bingham	26	42.1	20	-	3	-	1	2	13	12	1
Blaine	32	192.8	29	-	-	-	-	3	16	16	-
Boise	1	24.4	-	-	-	-	-	1	-	-	1
Bonner	47	118.1	45	-	-	-	-	2	-	-	47
Bonneville	68	38.2	55	1	2	2	3	5	42	23	3
Boundary	6	40.8	4	-	-	-	-	2	-	-	6
Butte	2	69.0	2	-	-	-	-	-	2	-	-
Camas	-	-	-	-	-	-	-	-	-	-	-
Canyon	319	99.8	273	3	4	7	5	27	203	99	17
Caribou	1	10.4	1	-	-	-	-	-	1	-	-
Cassia	35	91.1	32	-	-	1	-	2	14	20	1
Clark	2	222.2	2	-	-	-	-	-	-	1	1
Clearwater	3	41.1	2	-	-	-	-	1	1	-	2
Custer	-	-	-	-	-	-	-	-	-	-	-
Elmore	31	73.6	25	1	-	1	-	4	25	4	2
Franklin	7	33.8	4	1	-	-	1	1	5	1	1
Fremont	4	25.8	3	-	-	-	-	1	2	2	-
Gem	13	62.5	13	-	-	-	-	-	12	1	-
Gooding	15	90.4	13	-	-	-	-	2	11	4	-
Idaho	6	49.6	5	-	1	-	-	-	-	-	6
Jefferson	11	24.8	11	-	-	-	-	-	7	4	-
Jerome	34	101.8	33	-	-	-	-	1	12	22	-
Kootenai	183	99.9	169	2	2	1	1	8	4	-	179
Latah	39	93.1	29	1	-	1	-	8	-	-	39
Lemhi	4	75.5	3	-	1	-	-	-	4	-	-
Lewis	2	47.6	1	-	1	-	-	-	1	-	1
Lincoln	7	125.0	6	-	-	-	-	1	2	5	-
Madison	13	12.0	11	2	-	-	-	-	10	2	1
Minidoka	18	66.7	15	1	-	-	1	1	6	11	1
Nez Perce	40	89.3	29	-	2	2	1	6	-	-	40
Oneida	-	-	-	-	-	-	-	-	-	-	-
Owyhee	8	57.1	7	-	1	-	-	-	8	-	-
Payette	27	84.4	25	-	-	-	-	2	21	4	2
Power	2	23.3	2	-	-	-	-	-	1	1	-
Shoshone	12	81.6	10	-	1	-	-	1	2	-	10
Teton	1	7.9	-	-	-	1	-	-	1	-	-
Twin Falls	112	101.4	98	4	1	-	2	7	85	24	3
Valley	14	160.9	14	-	-	-	-	-	11	3	-
Washington	10	103.1	10	-	-	-	-	-	8	1	1

1. Induced abortion ratio: Number of induced abortions per 1,000 live births.
2. Race and ethnicity are reported separately on the abortion report; women of Hispanic origin are included in appropriate race totals.

*Total in 2020 includes 2 abortions in which county and district of residence was unknown (two White race, one Non-Hispanic, and one ethnicity unknown).

INDUCED ABORTIONS TO IDAHO RESIDENTS
Age, Abortion Rate, and Abortion Ratio
2010-2020

AGE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IDAHO RESIDENT	2,123	2,005	1,916	1,794	1,751	1,686	1,749	1,730	1,742	1,892	2,007
Age:											
10-14	13	6	8	4	7	4	4	3	7	4	9
15-19	344	328	314	224	233	215	219	211	202	241	238
15-17	113	97	102	62	56	71	62	57	64	59	56
18-19	231	231	212	162	177	144	157	154	138	182	182
20-24	722	649	621	620	572	567	594	543	555	571	644
25-29	470	450	457	445	439	387	431	426	456	479	499
30-34	333	331	290	245	270	260	292	299	278	315	350
35-39	175	159	139	179	159	185	150	190	194	207	198
40-44	61	76	74	66	62	58	51	51	44	68	61
45+	4	3	7	7	7	9	6	6	5	7	8
Not stated	1	3	6	4	2	1	2	1	1	0	0
Abortion rate per 1,000 females in age group											
Total[1]	6.9	6.5	6.2	5.8	5.6	5.3	5.4	5.3	5.2	5.5	5.7
Age[2]:											
10-14	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1
15-19	6.1	5.7	5.7	4.0	4.2	3.8	3.8	3.6	3.3	3.9	3.8
15-17	3.4	2.9	3.0	1.8	1.6	2.0	1.7	1.5	1.7	1.6	1.4
18-19	10.0	9.8	9.7	7.5	8.2	6.5	7.2	6.9	5.9	7.7	7.7
20-24	13.5	12.0	11.2	11.4	10.7	10.7	11.2	10.1	10.2	10.3	11.3
25-29	9.1	8.7	8.9	8.6	8.2	7.1	7.8	7.5	7.9	8.1	8.5
30-34	6.7	6.4	5.6	4.6	5.1	4.9	5.4	5.5	5.0	5.5	5.9
35-39	3.7	3.4	2.9	3.7	3.2	3.6	2.8	3.4	3.4	3.5	3.3
40-44	1.3	1.6	1.5	1.4	1.3	1.2	1.1	1.0	0.9	1.3	1.1
45+	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.2
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Abortion ratio per 1,000 live births in age group											
Total[3]	91.5	89.9	83.5	80.3	76.5	73.8	77.9	78.1	81.4	85.7	93.2
Age:											
10-14	1,000.0	400.0	888.9	363.6	1,000.0	363.6	571.4	300.0	1,750.0	500.0	1,125.0
15-19	184.5	207.1	200.4	157.1	179.0	167.3	187.3	191.0	208.0	262.8	261.8
15-17	223.8	251.9	260.9	199.4	180.1	237.5	222.2	263.9	303.3	313.8	285.7
18-19	170.0	192.7	180.3	145.3	178.6	146.0	176.4	173.2	181.6	249.7	255.3
20-24	114.0	106.2	99.1	105.9	93.1	98.9	106.5	100.8	108.7	111.1	130.9
25-29	62.1	63.0	62.5	61.1	60.8	52.8	60.1	58.5	65.4	66.7	71.1
30-34	65.9	64.9	54.6	47.2	49.3	46.5	51.3	55.1	52.1	56.5	63.6
35-39	90.3	82.9	69.4	84.8	70.3	77.9	64.5	77.0	76.4	76.4	75.8
40-44	151.7	180.1	167.0	153.1	139.6	125.8	104.3	114.6	99.8	134.9	113.4
45+	111.1	150.0	259.3	184.2	259.3	272.7	181.8	157.9	178.6	189.2	285.7
Not stated	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

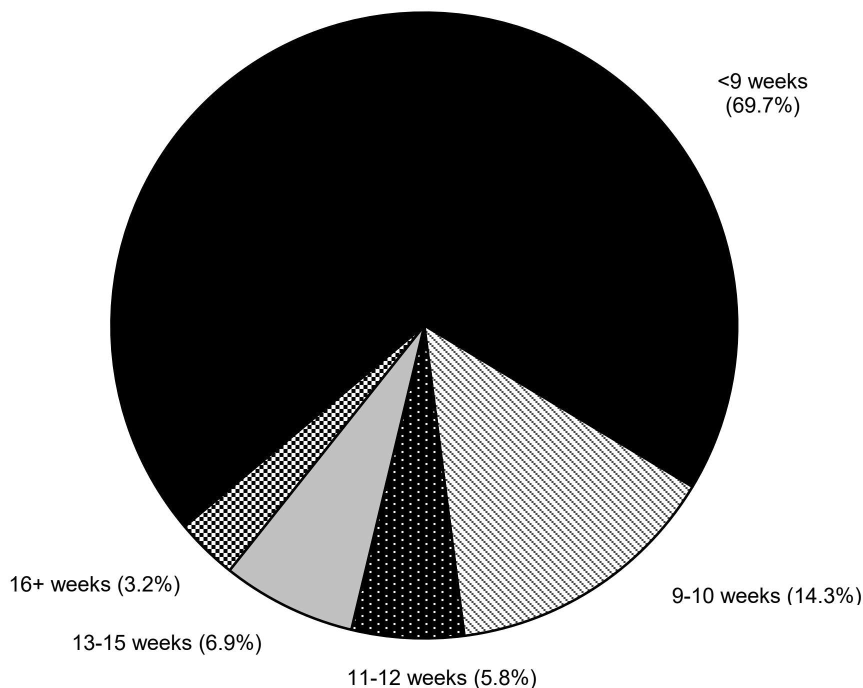
1. Total abortion rate: Number of induced abortions to women of all ages per 1,000 females 15-44 years of age.
   Rates for 2011-2020 are based on July 1, 2009-July 1, 2020 population estimates from the U.S. Census Bureau and NCHS, Internet release dates July 2012, June 2013, June 2014, June 2015, June 2016, June 2017, June 2018, June 2019, June 2020, and September 2021.
   Rates for April 1, 2010 are based on Census data, Internet released May 12, 2011.
2. Rate for 45+ age group is based on the population of women 45-49 years of age.
3. Total abortion ratio: Number of induced abortions per 1,000 live births.

NA - not applicable.

INDUCED ABORTIONS TO IDAHO RESIDENTS
Primary Termination Procedure by Clinical Estimated Length of Gestation*
2020

TERMINATION PROCEDURE	TOTAL	WEEKS OF GESTATION							
		<9	9-10	11-12	13-15	16-20	21-24	25+	Not Stated
TOTAL RESIDENTS OF IDAHO	2,007	1,396	287	116	139	43	17	4	5
Suction curettage	781	447	140	104	75	11	1	-	3
Medical (nonsurgical)	1,102	946	145	3	4	1	1	1	1
Dilation and evacuation (D&E)	119	-	2	9	58	31	15	3	1
Intra-uterine instillation (saline / prostaglandin)	1	-	-	-	1	-	-	-	-
Sharp curettage (D&C)	2	2	-	-	-	-	-	-	-
Hysterotomy / Hysterectomy	-	-	-	-	-	-	-	-	-
Other	1	1	-	-	-	-	-	-	-
Not stated	1	-	-	-	1	-	-	-	-

INDUCED ABORTIONS TO IDAHO RESIDENTS
Clinical Estimated Length of Gestation
2020



Percentages are based on records with known data for length of gestation.

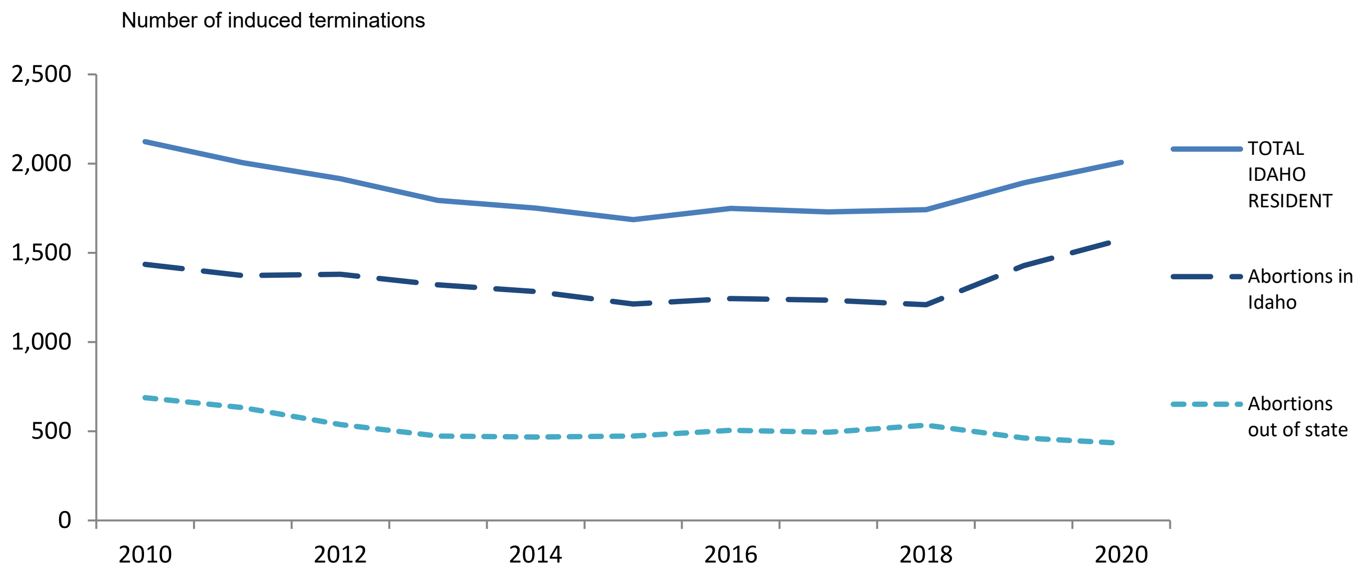
* The clinical estimated length of gestation may differ from length of gestation based on the date of last normal menses and date of pregnancy termination. The primary procedure that terminated the pregnancy is shown; there may be additional procedures used for the termination.

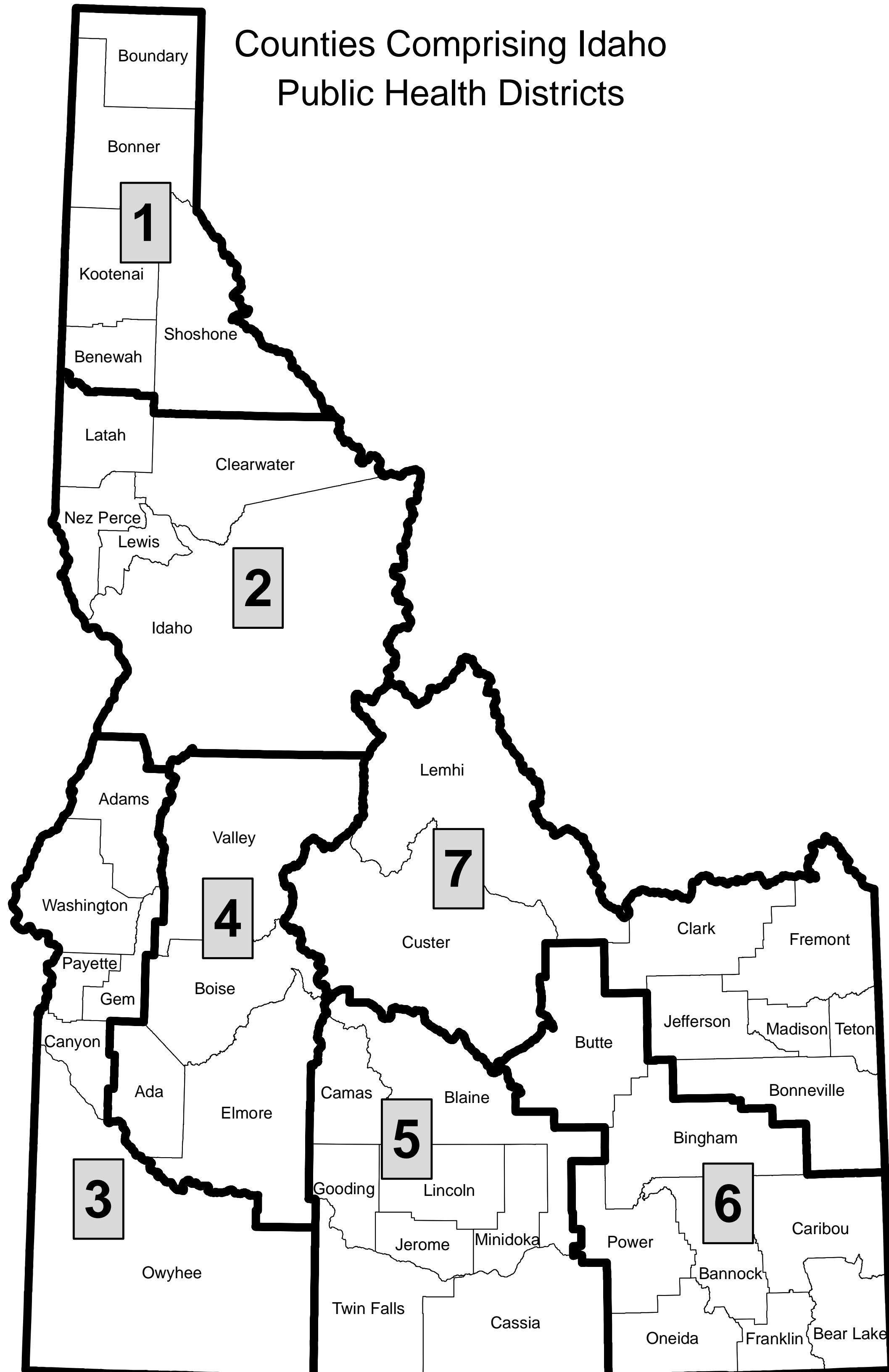
Abortions to Idaho residents may have occurred in Idaho or out of state.

INDUCED ABORTIONS TO IDAHO RESIDENTS
State of Occurrence
2010-2020

STATE OF OCCURRENCE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL IDAHO RESIDENT	2,123	2,005	1,916	1,794	1,751	1,686	1,749	1,730	1,742	1,892	2,007
Abortions in Idaho	1,435	1,372	1,379	1,321	1,283	1,213	1,244	1,235	1,209	1,429	1,574
Abortions out of state	688	633	537	473	468	473	505	495	533	463	433
Montana	59	36	48	28	18	21	13	16	20	24	14
Oregon	31	30	18	21	14	12	32	21	26	25	15
Utah	160	156	108	92	79	86	129	79	68	59	44
Washington	438	410	362	332	356	354	331	378	419	354	359
All other	-	1	1	-	1	-	-	1	-	1	1

INDUCED ABORTIONS TO IDAHO RESIDENTS
State of Occurrence
2010-2020





District 1	District 2	District 3	District 4	District 5	District 6	District 7
Benewah	Clearwater	Adams	Ada	Blaine	Bannock	Bonneville
Bonner	Idaho	Canyon	Boise	Camas	Bear Lake	Clark
Boundary	Latah	Gem	Elmore	Cassia	Bingham	Custer
Kootenai	Lewis	Owyhee	Valley	Gooding	Butte	Fremont
Shoshone	Nez Perce	Payette		Jerome	Caribou	Jefferson
		Washington		Lincoln	Franklin	Lemhi
				Minidoka	Oneida	Madison
				Twin Falls	Power	Teton

TECHNICAL NOTES

Induced Abortion

Termination Procedure

The primary procedure that terminated this pregnancy.

Suction Curettage
(Also known as vacuum aspiration)-In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter (dilators). When the cervix is sufficiently dilated, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then removed using an electric vacuum pump.

Medical (Nonsurgical)
This nonsurgical procedure involves the administration of a medication or medications to induce an abortion. Medications (e.g. methotrexate, mifepristone, misoprostol, etc.) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g. prostaglandin suppositories, injectable prostaglandins, etc.) may be administered during the second trimester of pregnancy to induce abortion. Medications may be administered orally, by injection, or intravaginally.

Dilation and Evacuation (D&E)
This procedure, used most frequently in the second trimester of pregnancy (greater than or equal to 13 weeks' gestation) involves opening the cervix (dilation) and primarily using sharp instrument techniques, but also suction and other instrumentation such as forceps for evacuation.

Intrauterine Instillation (Saline or Prostaglandin)
This procedure involves either withdrawing a portion of the amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated salt solution (known as saline instillation, saline abortion, or saline amniotic fluid exchange) or injecting a prostaglandin – a substance with hormone-like activity- into the uterine cavity through a needle inserted through the abdominal wall (known as intrauterine prostaglandin instillation). The saline instillation process induces labor, which results in the expulsion of the fetus approximately 24 to 48 hours later. The interval between prostaglandin injection and expulsion tends to be shorter than in a saline abortion.

Sharp Curettage (D&C)
(Also known as dilation and curettage, D&C, or surgical curettage)-This procedure involves the dilation of the cervix as in the section curettage procedure, although usually to a larger diameter. The fetal and placental tissues are then removed with a sharp curette.

Hysterotomy/Hysterectomy
Hysterotomy involves surgical entry into the uterus to remove a fetus. Hysterotomy is usually performed only if other abortion procedures fail or if other abortion procedures are not appropriate. Hysterectomy is a procedure in which the uterus is removed (with the fetus inside). It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.

Note there may be one or more procedure used to terminate the pregnancy.

Complications of Termination

Beginning in 2019, complications are no longer reported on the Induced Termination report filed with the Bureau of Vital Records and Health Statistics. Complications are reported on a separate Abortion Complications Report. Data from the Abortion Complications Report are based on the year the report is filed with Bureau of Vital Records and Health Statistics; the abortion may have occurred in the same year as the complication or the abortion may have occurred year(s) prior to the complication. For information regarding the Abortion Complications Reporting Act go to: https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH95/

Educational Materials

Was the patient provided the education materials as specified in Idaho Code § 18-609(4)? Education materials include information on induced termination, fetal development, and services for women, infants, and children in Idaho.

Clinical Estimate of Gestation

The length of gestation as estimated by the attending physician in completed menstrual weeks. This estimate is not computed from the date last normal menses began and date of termination. Clinical estimate of gestation is used for the length of gestation.

Postfertilization Age

Age calculated from the date of fertilization of the human ovum. The termination record does not collect the date of fertilization. Fertilization of the human ovum occurs approximately two weeks after the onset of menses. The postfertilization age is calculated to by the number of completed weeks' clinical estimate of gestation minus two weeks. For example, 20 weeks postfertilization is equal to 22 weeks' clinical estimate of gestation.

Method for Determining Gestational Age

The method used by the attendant in determining the reported weeks of gestation.

Ultrasound
Weeks of gestation were determined by an ultrasound procedure

Pelvic Exam
Weeks of gestation were determined by a pelvic examination procedure

Other, Specify
Indicate what method/procedure/evidence the attendant used to determine the weeks of gestation

None
A clinical estimate of gestation was not performed.

Race

Patient's race is a write-in category for one race. If race is written as "Hispanic", "Mexican", or "Latina", the patient's race is categorized as "white". If race is written as "other", "mixed race", or "multi race" the patient's race is categorized as "other".

Ethnicity

Patient's ethnicity is reported separately from race on the induced termination record. Ethnicity is reported as a check box of yes or no for the question "Of Hispanic origin?". If checked "yes", Hispanic origin is specified as Cuban, Mexican, Puerto Rican,

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Idaho Department of Health and Welfare.
HW-1206 January 2022