Nos. 23-726 and 23-727

In The Supreme Court of the United States

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

v.

UNITED STATES,
Respondent.

STATE OF IDAHO,
Petitioner,

v.

UNITED STATES,
Respondent.

On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF NATIONAL WOMEN'S LAW CENTER, IN OUR OWN VOICE: NATIONAL BLACK WOMEN'S REPRODUCTIVE JUSTICE AGENDA, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE JUSTICE AND 98 ADDITIONAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

MICHELLE BANKER
GRETCHEN BORCHELT
DORIANNE MASON
LEILA ABOLFAZLI
LEXI RUMMEL
DONYA KHADEM
KENNA TITUS
NATIONAL WOMEN'S LAW CENTER
1350 I St. NW, Ste. 700
Washington, DC 20005
Tel: (202) 588-5180
mbanker@nwlc.org

March 28, 2024

CHRISTINE E. WEBBER
Counsel of Record
ALISON S. DEICH
ANIKO R. SCHWARCZ
HARINI SRINIVANSAN
NINA C. JAFFE-GEFFNER
SABRINA S. MEROLD
ANN SIMONE NISSENBAUM SARNAK
COHEN MILSTEIN SELLERS & TOLL PLLC
1100 New York Ave. NW, Ste. 500
Washington, DC 20005
Tel: (202) 408-4600
Fax: (202) 408-4699
cwebber@cohenmilstein.com
adeich@cohenmilstein.com

Counsel for Amici Curiae

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

OTHER AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

INTEREST OF THE *AMICI CURIAE*[1]

The National Women's Law Center is a nonprofit legal advocacy organization founded in 1972 dedicated to the advancement and protection of legal rights and opportunities for women,[2] girls, and all who face sex discrimination. The Center focuses on issues including economic security, workplace justice, education, and health, including reproductive rights, with particular focus on the needs of those who face multiple and intersecting forms of discrimination. Because access to healthcare including, and especially, emergency obstetric care—is of tremendous significance to health equity and the health and wellbeing of all who can become pregnant, the Center seeks to ensure that pregnant patients have access to emergency obstetric care, including abortion care, and has participated as an *amicus* in this Court and before numerous other courts to help secure the right to an abortion.

This brief is also submitted on behalf of In Our Own Voice: National Black Women's Reproductive Justice Agenda, National Asian Pacific American Women's Forum, and National Latina Institute for Reproductive

---

[1] No counsel for a party authored this brief in whole or in part. No party or party's counsel financially supported this brief, and no one other than *amici* and their counsel financially contributed to this brief.

[2] While this brief sometimes refers to a woman's right to emergency obstetric care, including abortion, *amici* recognize that individuals who do not identify as women, including transgender men and non-binary persons, also may become pregnant and are equally entitled to protection of their right to stabilizing emergency treatment.

Justice, as well as 98 organizations listed in the Appendix to this brief. Like the Center, these organizations are committed to equitable and adequate healthcare access for everyone who is pregnant or can become pregnant.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

The Emergency Medical Treatment and Labor Act (EMTALA) is a life raft for people who have systematically been denied medical care. Recognizing the cruelty of denying medical treatment to patients in crisis, Congress created EMTALA to ensure that Medicare-funded hospitals would, at the very least, provide "necessary stabilizing treatment" for "any" patient with an "emergency medical condition," regardless of the patient's ability to pay. 42 U.S.C. § 1395dd(b). In 1989, Congress amended the statute to clarify and extend protections for pregnant people. The plain text of EMTALA now requires that emergency departments stabilize pregnant patients in labor, pregnant patients who have emergency conditions unrelated to labor, and patients who need emergency treatment to prevent pregnancy loss. Because more than half of pregnant people seek emergency department treatment at some point during their pregnancy, and up to 15% suffer a life-threatening condition during the first trimester,

EMTALA's safeguards are critical for everyone who can become pregnant in the United States.[3]

The importance of EMTALA has only increased as this country reckons with a maternal health crisis. While structural barricades to quality prenatal care were erected long ago—particularly for pregnant patients in Black and Indigenous communities—rates of severe and fatal pregnancy complications in the United States are rising. The crisis has now reached fever pitch: The United States' maternal mortality rate is ten times that of other high-income countries. And while the risk of pregnancy-related death is unacceptably high across demographic groups, it is worst for Black women, who are three times as likely to die as white women, and Indigenous women, who are twice as likely to die as white women.

In the wake of *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), Idaho raises the novel theory that it has the power to carve protections for pregnant people out of federal law. Accepting Idaho's reading of EMTALA—which distorts the statutory text beyond reason and recognition—would deepen the United States' maternal health crisis, particularly for Black, Indigenous, immigrant, rural, and low-income communities. It would decimate treatment options for patients experiencing pregnancy-related emergencies and accelerate the exodus of healthcare

---

[3] Glenn Goodwin et al., *A National Analysis of ED Presentations for Early Pregnancy and Complications: Implications for Post-*Roe *America*, 70 Am. J. Emerg. Med. 90 (2023), https://bit.ly/3TTfCYt.

providers from areas that are already considered pregnancy-care deserts, making even routine pregnancy care harder to find. *Amici* urge the Court to reject Petitioners' atextual reading of EMTALA and prevent the catastrophic consequences that would flow from it.

ARGUMENT

I. EMTALA PROTECTS ACCESS TO ALL EMERGENCY MEDICAL TREATMENT, INCLUDING EMERGENCY ABORTION CARE.

The plain language of EMTALA ensures meaningful access to emergency healthcare for everyone, including pregnant people. The statute requires that Medicare-participating hospitals: (1) perform an "appropriate medical screening examination," on "any individual" who comes to the "emergency department" (the Screening Requirement), 42 U.S.C. § 1395dd(a); and (2) provide "necessary stabilizing treatment" to any "individual" who has an "emergency medical condition" (the Stabilization Requirement), *id.* § 1395dd(b). An "emergency medical condition" (EMC) is any condition that, in "the absence of immediate medical attention could reasonably be expected to result in": "(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1)(A).

For some pregnant patients with EMCs, including prolonged miscarriages, the "necessary stabilizing treatment" is terminating the pregnancy in a medical setting, where healthcare providers can guard against the risks of infection, hemorrhage, and stroke (among others). Under these circumstances, EMTALA is clear: The hospital must offer to end the pregnancy.

Petitioners' novel arguments to the contrary cannot be squared with the law's "plain terms." *Bostock v. Clayton Cnty.*, 590 U.S. 644, 674 (2020). EMTALA's reference to "unborn child[ren]" creates protections for pregnant patients who need emergency treatment to avoid pregnancy loss; it does not strip protections from patients who need life- and health-saving abortion care. 42 U.S.C. § 1395dd(e)(1)(A)(i). Nor does EMTALA limit "stabilizing treatment" to treatment allowed by state law.

A. EMTALA Has Always Required Hospitals to Offer Emergency Abortion Care.

Protecting pregnant patients is a core function of EMTALA. "Labor" is the only medical condition named in the title and text of the law, 42 U.S.C. § 1395dd, and the statute expressly protects "a pregnant woman who is having contractions" if her "health or safety" is at risk. *Id.* §§ (b)(1), (e)(1)(B). The statute also specifies that a "pregnant woman"—like any other "individual"—is entitled to stabilizing treatment if she has *any* medical condition that places her health in "serious

jeopardy," regardless of whether she is in labor. *Id.* §§ (b)(1), (e)(1)(A).[4]

For both pregnant and non-pregnant patients, EMTALA's Stabilization Requirement is straightforward and unqualified. *See Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 253 (1999). EMTALA states that, if "*any* individual" is diagnosed with an EMC, the hospital "must provide . . . within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition," (or, under limited circumstances, for a medically beneficial transfer to another healthcare facility). 42 U.S.C. § 1395dd(b)(1) (emphasis added). To "stabilize" a pregnant patient in labor, the hospital must help the patient "deliver (including the placenta)." *Id.* § 1395dd(e)(3)(B). And to "stabilize" a non-pregnant patient or a pregnant patient with an EMC other than (or in addition to) labor, the hospital must provide the care necessary to "assure, within reasonable medical probability, that no material deterioration of the condition is likely." *Id.* § 1395dd(e)(3)(A). *Id.* Thus, the Stabilization Requirement ensures that, if an individual comes to a Medicare-funded hospital with a serious medical

---

[4] *See, e.g.*, *Lopez v. Contra Costa Reg'l Med. Ctr.*, No. C 12-03726 LB, 2013 WL 1402596, at *1 (N.D. Cal. Apr. 5, 2013) (severe preeclampsia involving hemolysis, elevated liver function, and low platelets (HELLP syndrome) was an EMC requiring stabilizing treatment); *Vazquez-Rivera v. Hosp. Episcopal San Lucas, Inc.*, 620 F. Supp. 2d 264, 270 (D.P.R. 2009) (pregnant patient's "vaginal bleeding[ ] and severe abdominal pain" was an EMC (citation omitted)).

emergency, the hospital will provide the bare minimum care necessary to guard against catastrophic outcomes.

Occasionally, a hospital cannot satisfy the Stabilization Requirement unless it offers a specific course of treatment for a patient. For example, a child with serious breathing difficulties may need "aggressive treatment, including mechanical ventilation" to assure, "within reasonable medical probability, that no material deterioration" of her condition is "likely." *In re Baby "K"*, 16 F.3d 590, 594 (4th Cir. 1994) (internal quotation marks omitted). Under those circumstances, a "straightforward application of the statute" requires the hospital to offer the treatment that will stabilize the patient. *Id.*

For some pregnant patients experiencing an EMC, abortion care is the necessary stabilizing treatment. For example, if a pregnant patient experiences a preterm premature rupture of amniotic membranes (PPROM) before the fetus is capable of surviving outside the uterus, pregnancy loss is often inevitable, but waiting for the pregnant patient to miscarry without medical support could cause sepsis, hemorrhage, severe and lasting organ damage, and loss of fertility.[5] As a result, terminating the pregnancy promptly may be necessary to "assure, within reasonable medical probability, that no material deterioration" is "likely."

---

[5] Kimberly Chernoby and Brian Acunto, *Pregnancy Complications After* Dobbs*: The Role of EMTALA*, 25 West J. Emerg. Med. 79 (2024), https://bit.ly/3INZfWN.

42 U.S.C. § 1395dd(e)(3)(A). Similarly, for patients who develop severe hypertensive disorders before their fetuses are viable, ending the pregnancy may be the only treatment that can adequately guard against the risk of debilitating (if not fatal) strokes.[6] Under these and other emergency circumstances, EMTALA requires that the hospital offer emergency abortion care (or, if permitted by 42 U.S.C. § 1395dd(c), a transfer to a facility that will provide the abortion care). 42 U.S.C. § 1395dd(b).

Congress affirmed this interpretation of EMTALA as recently as 2010 in Section 1303 of the Affordable Care Act (ACA), which lists "special rules" for insurance coverage of abortion in ACA-marketplace plans. 42 U.S.C. § 18023. Section 1303 provides: "Nothing in this Act shall be construed to *relieve any health care provider from providing emergency services* as *required* by State or Federal law, *including* . . . '*EMTALA'[ ].*" *Id.* § 18023(d) (emphasis added). This language confirms that medical providers are "required" to offer abortion-related "emergency services" under EMTALA and clarifies that nothing in the ACA "relieve[s]" providers of that obligation.

The United States' position here is not a post-*Dobbs* invention; it has *always* recognized that

---

[6] *See, e.g.*, Memorandum from Ctrs. for Medicare & Medicaid Servs. on Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (July 11, 2022) (on file with author), https://go.cms.gov/3vr1pbH; *Pregnancy and Stroke: Are You at Risk?*, Ctrs. for Disease Control & Prevention (May 4, 2023), https://bit.ly/3Pwyjyf.

EMTALA protects emergency abortion access. The United States Department of Health and Human Services (HHS) has consistently recognized that EMTALA requires hospitals to provide emergency abortion care, notwithstanding a collection of federal statutes (Refusal Laws) "that aim, in discrete contexts, to accommodate [individuals'] religious and moral objections" to specific medical procedures. *New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 497 (S.D.N.Y. 2019). For example, in a 2008 regulatory preamble, HHS suggested that a hospital would run afoul of EMTALA if the entire "hospital, as opposed to an individual, ha[d] an objection to performing abortions that are necessary to stabilize the mother." *Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008) (2008 Refusal Rule). HHS reiterated this view in a 2019 preamble. *Protecting Statutory Conscience Rights in Health Care*, 84 Fed. Reg. 23,170, 23,183 (May 21, 2019) (2019 Refusal Rule) ("With respect to EMTALA, the Department generally agrees with its explanation in the preamble to the 2008 Rule.").[7]

Federal courts have likewise recognized that EMTALA requires stabilizing abortions. For example,

---

[7] HHS has since largely repealed both rules. *See Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011); *Safeguarding the Rights of Conscience as Protected by Federal Statutes*, 88 Fed. Reg. 820, 824 (Jan. 5, 2023).

the 2019 Refusal Rule was vacated because it did not provide adequate protections for the stabilizing abortion care that EMTALA requires (among other legal deficiencies). *United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d at 538. And in a 2008 decision involving a challenge to the Weldon Amendment (which concerns refusals of abortion care), the court recognized that "required medical treatment" under EMTALA includes "abortion-related services." *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008).[8]

In sum, the United States is not proposing a "novel" interpretation of EMTALA. Br. for the Pet'r Idaho (Idaho Br.) 30, Feb. 20, 2024. It is simply reaffirming a decades-long consensus across Congress, regulators, and courts that EMTALA protects "any and all patients" facing serious medical emergencies, including patients who need abortion care. *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991).

B. The Court Should Reject Petitioners' Attempt to Rewrite EMTALA.

In the wake of *Dobbs*, Idaho insists that it has the power to carve protections for pregnant people out of EMTALA. The Court should reject Idaho's attempt to rewrite federal law.

---

[8] The *California* court ultimately found California's claim to be nonjusticiable. *California*, 2008 WL 744840, at *4.

1. EMTALA's Reference to "Unborn Child[ren]" Does Not Eliminate the Right to Stabilizing Abortion Care.

Petitioners incorrectly insist that a 1989 amendment to EMTALA—which requires Medicare-funded hospitals to offer stabilizing treatment to a "pregnant woman" if her own health or the health of her "unborn child" is in jeopardy—*sub silentio* removes protections for patients who need stabilizing abortion care. Br. of Pet'rs Mike Moyle et al. (Moyle Br.) 4, February 20, 2024. This argument is unmoored from both the text of the statute and medical reality.

As originally enacted, EMTALA required hospitals to provide "necessary stabilizing treatment" for "emergency medical conditions" or "active labor." Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 166 (1985). In 1989, Congress amended the statute to clarify that it protects pregnant patients with medical emergencies unrelated to labor and to *extend* protections to patients at risk of pregnancy loss. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h), 103 Stat. 2248 (1989) (1989 Amendment). The amendment accomplished these dual goals by broadening the definition of an EMC to include any condition that, in the "absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A).

For the first time in nearly thirty-five years, Petitioners argue that the 1989 Amendment's clear effort to expand protection for pregnant patients in fact allows Medicare-funded hospitals to deny pregnant patients—and pregnant patients alone—life- and health-saving treatment. But the 1989 Amendment did not, as Petitioners suggest, open the door for hospitals to sacrifice the health of a "pregnant woman" for "her unborn child." Moyle Br. 4.

In many cases where a pregnant patient has an EMC requiring emergency abortion care—rather than delivery of a fetus capable of surviving outside the uterus—pregnancy loss is inevitable.[9] It is unthinkable that Congress amended EMTALA to deny life- and health-saving medical treatment to a pregnant patient to "stabilize" a fetus with no chance of survival. *Cf. Morin v. E. Maine Med. Ctr.*, 779 F. Supp. 2d 166, 185 (D. Me. 2011) (rejecting the "disquieting notion" that EMTALA does not protect pregnant people who cannot "deliver a live infant" (citation omitted)).

In the rare case where there is a decision to be made between stabilizing a pregnant patient and preserving a viable pregnancy, EMTALA gives that decision to the pregnant patient. If a pregnant "individual" has an EMC, and it is not possible to provide stabilizing treatment that preserves the pregnancy, EMTALA leaves only one way for the hospital to satisfy its

---

[9] Daniel Grossman et al., *Care Post-*Roe*: Documenting cases of poor-quality care since the* Dobbs *decision*, Advancing New Standards in Reprod. Health at 8 (May 2023), https://bit.ly/49gFrWx.

stabilization obligations: The hospital must "offer[] the individual" a stabilizing abortion, and get the individual's "written informed consent" to accept or refuse it. 42 U.S.C. §§ 1395dd(b)(1)-(2).

2. "Stabilizing Treatment" Is Not Limited to Treatment Permitted by State Law.

Petitioners also suggest, incorrectly, that EMTALA only requires hospitals to provide stabilizing care permissible under state law. Moyle Br. 16-17. Petitioners argue that the Stabilization Requirement creates a duty to provide care "within the staff and facilities *available at the hospital*," and treatments that are illegal under state law are not "available." Idaho Br. 25 (quoting 42 U.S.C. § 1395dd(b)(1)). That assertion reads the phrase "staff and facilities" out of the statute. *See, e.g.*, *Rubin v. Islamic Republic of Iran*, 583 U.S. 202, 213 (2018) (a "statute should be construed so that effect is given to all its provisions" and "no part will be inoperative or superfluous") (internal quotation marks omitted). EMTALA plainly states that, if a hospital cannot stabilize a patient because it does not have the necessary "*staff and facilities*," the hospital may "transfer" a patient "to another medical facility in accordance with subsection (c)." 42 U.S.C. § 1395dd(b)(1) (emphasis added). But if the sole obstacle to providing stabilizing treatment is state law, EMTALA provides a different solution: Federal law preempts the state restriction. 42 U.S.C. § 1395dd(f).

Petitioners' argument also ignores the careful and contrasting language in EMTALA's provisions. Unlike the Screening Requirement, which calls for an "appropriate medical screening," 42 U.S.C. § 1395dd(a), the Stabilization Requirement speaks in broad an unqualified terms: Hospitals must provide "necessary stabilizing treatment." *Id.* § 1395dd(b); *see Roberts*, 525 U.S. at 253 ("[T]here is no question that the text of § 1395dd(b) does not require an 'appropriate' stabilization, nor can it reasonably be read to require an improper motive."). Contrary to this Court's clear instructions in *Roberts*, Petitioners are placing a limiting gloss on the Stabilization Requirement by insisting—without any textual grounding—that EMTALA only requires stabilizing care approved by states.

Petitioners' reading of the Stabilization Requirement is particularly implausible because, when EMTALA means to incorporate state law, it says so expressly. EMTALA's civil damages provision allows individuals injured by EMTALA violations to obtain only "those damages available for personal injury under the law of the State in which the hospital is located." 42 U.S.C. § 1395dd(d)(2)(A). The Stabilization Requirement, however, contains no such limitation. The implication of that omission is clear: The Stabilization Requirement is not cabined by state law. *See Russello v. United States*, 464 U.S. 16, 23 (1983) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress

acts intentionally. . . .” (brackets and internal quotation marks omitted)).

In sum, the Court should reject Petitioners’ atextual reading of EMTALA, which would perversely single pregnant patients out for disfavorable if not deadly treatment.

II. CARVING PROTECTIONS FOR PREGNANT PATIENTS OUT OF EMTALA WILL DEEPEN THIS COUNTRY’S PROFOUND MATERNAL HEALTH CRISIS.

Access to healthcare in the United States has long hinged on patients’ sex, race, ethnicity, income, immigration status, and zip code—a reality that undergirds EMTALA’s mandate that all patients receive stabilizing emergency care. EMTALA’s protections are particularly important for pregnant patients from communities facing systemic oppression and disinvestment, who often cannot access the preventive care necessary to avert life-threatening pregnancy complications.

Rates of severe and fatal pregnancy complications in the United States have reached crisis levels: Pregnancy in this country is now ten times more lethal than in other high-income countries. While the crisis affects all people who are or may become pregnant, it disproportionately harms Indigenous and Black patients, who die of pregnancy-related causes at double and triple the rates of white patients, respectively.

Petitioners' challenge to EMTALA comes at a time when abortion bans are colliding with abiding structural racism and the ongoing crisis in maternity care. This perfect storm is preventing pregnant patients from receiving life- and health-saving medical care and driving obstetric providers out of areas where pregnancy care is already dangerously difficult to access. The consequences of gutting EMTALA now are predictable and devastating: More pregnant people will suffer and die.

A. Black, Indigenous, Latinx, AAPI, Immigrant, and Rural Communities Face Significant Barriers to Primary and Pregnancy-Related Healthcare, Increasing Their Risk of Pregnancy Emergencies.

Pregnant people in the United States must navigate a healthcare system rooted in laws that deliberately and systematically denied equal healthcare access to people of color.[10] The legacy of those racist laws is a network of mutually reinforcing barriers to quality healthcare for millions of people, particularly in Black, Indigenous, Latinx, Asian American and Pacific Islander (AAPI), immigrant, and rural

[10] For example, the federal 1946 Hospital Survey and Construction Act permitted racially segregated healthcare facilities. Over the next twenty years, state governments levied policies that disproportionately excluded racial and ethnic minority populations from Medicare and Medicaid. Ruqaiijah Yearby et al., *Structural Racism in Historical and Modern US Health Care Policy*, 41 Health Affairs 187, 188 (2022), https://bit.ly/4cuHUja.

communities. Several of these barriers make routine primary and pregnancy-related care dangerously difficult to access, including: (1) lack of health insurance; (2) discrimination and language barriers; and (3) maternity care deserts. When people cannot access primary care prior to pregnancy, they are more likely to develop underlying conditions that make pregnancy more dangerous, such as chronic hypertension, heart disease, diabetes, kidney disease, venous thromboembolism, and obesity.[11] These risks are compounded when patients cannot access adequate prenatal care.[12] Thus, structural barriers to routine healthcare make emergency pregnancy complications all too common.

Lack of Health Insurance. Without insurance, patients often struggle to afford care for chronic health conditions that make pregnancy more dangerous.[13] Similarly, because prenatal care requires frequent[14]

---

[11] S. Michelle Ogunwole et al., *Interconception Care for Primary Care Providers: Consensus Recommendations on Preconception and Postpartum Management of Reproductive-Age Patients With Medical Comorbidities*, 5 Mayo Clin. Proc. Innov. Qual Outcomes 872, 872-73 (2021), https://bit.ly/3xa2mWx.

[12] Eunice Kennedy Shriver, *What is prenatal care and why is it important?*, Nat'l Inst. of Child Health & Hum. Dev. (Jan. 31, 2017), https://bit.ly/43uQ5YJ.

[13] Yhenneko J. Taylor et al., *Insurance Differences in Preventive Care Use and Adverse Birth Outcomes Among Pregnant Women in a Medicaid Nonexpansion State: A Retrospective Cohort Study*, 29 J. Women's Health 29, 29-30 (2020), https://bit.ly/4cHa9vc.

[14] Typical prenatal care involves between 10 and 15 obstetrician visits. Elizabeth Rivelli, *How Much Does It Cost To Have A Baby? 2024 Averages*, Forbes (Jan. 3, 2024, 5:56 AM),

and expensive[15] medical appointments, a lack of health insurance can place that care out of reach. Yet access to insurance coverage in the United States remains deeply inequitable. As a result of structural racism, Black, Indigenous, and Latinx populations are significantly more likely to be uninsured than white people,[16] as are Asian Americans, Native Hawaiians, and Pacific Islanders.[17] Immigration status also affects insurance access: Roughly one-third of immigrants in the United States lack insurance;[18] in stark contrast, just 9.5% of naturalized citizens and 7.7% of United States-born citizens are uninsured.[19] One driver of this disparity is that legal permanent residents—many of whom are Latinx and AAPI—are Medicaid ineligible for five years, *see* 8 U.S.C. § 1613(a), meaning that they are categorically excluded from an essential safety net provided to other Americans. These inequitable cost barriers make it more difficult to access the primary and

---

https://bit.ly/3xaLMWq. For a pregnancy with complications, the number would likely be higher.

[15] For uninsured patients, prenatal care costs between $1,000 and $3,000 on average. Talon Abernathy, *Average Prenatal Care Cost & How Health Insurance Covers It*, Value Penguin (Jan. 10, 2024), https://bit.ly/4cppd0p. *See also* Heather Hatfield, *What It Costs to Have a Baby*, WebMD (Mar. 4, 2013), https://wb.md/3vqNUss.

[16] Latoya Hill et al., *Health Coverage by Race and Ethnicity, 2010-2022*, KFF (Jan. 11, 2014), https://bit.ly/4aqgY2a.

[17] *Health Care Access*, Asian & Pacific Islander Am. Health Forum, https://bit.ly/3vC0KEe (last accessed Mar. 24, 2024).

[18] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, KFF (Dec. 18, 2023), https://bit.ly/49fnjwi.

[19] *Id.*

prenatal care necessary to avert pregnancy-related EMCs.

Discrimination and Language Barriers. Even when patients are insured and able to reach medical providers, discrimination, bias, and lack of language services compromise the quality of treatment that many patients receive. For example, a bevy of research shows that Black patients do not receive the same quality of care as their white peers. Black patients are forced to wait longer to receive emergency[20] and non-emergency medical treatment,[21] are offered inferior prescriptions and treatments, and are more frequently met with skepticism when they report their symptoms to healthcare providers.[22] Other patients of color and

---

[20] One study shows Black women wait significantly longer than both white men and white women to be seen by a provider when they arrive at a hospital emergency department with chest pain. Darcy Banco et al., *Sex and Race Differences in the Evaluation and Treatment of Young Adults Presenting to the Emergency Department With Chest Pain*, 11 J. of the Am. Heart Ass'n 2, 5-6, 8 (2022), https://bit.ly/3vvkZnb.

[21] Data reveals that Black patients requiring an organ transplant wait on average one year longer than white patients, though Black people are four times more likely than white people to develop kidney failure and experience the highest rates of heart failure. Jewel Mullen, *How our organ transplant system fails people of color*, Ass'n of Am. Med. Colleges (Nov. 29, 2022), https://bit.ly/43xjS2N.

[22] One study analyzing taped conversations between patients and physicians reveals that doctors are more likely to express skepticism about the symptoms Black patients report. Another study of patient records shows that "doctors signal disbelief in the records of Black patients, appearing to question the credibility of their complaints by placing quotation marks around certain words." Roni Caryn Rabin, *How Unconscious Bias in Health Care*

LGBTQ+ patients also face discrimination in medical settings.[23] And for patients with limited English proficiency, providers often lack adequate translation services.[24]

Maternity Care Deserts. Over one-third of counties in the United States are "maternity care deserts," meaning that they have *no* obstetric providers, hospital-based obstetric care, or birth centers.[25] As a result of structural disinvestment in their reproductive health, Indigenous and Black pregnant patients—especially those in rural areas—feel the impact of maternity care deserts most acutely.[26] Counties with a higher percentage of Black women of reproductive age have

---

Puts Pregnant Black Women at Higher Risk, New York Times (Dec. 12, 2023), https://nyti.ms/3TpAfde; Anuli Njoku, *Listen to the Whispers before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States*, 11 Healthcare (Basel) 438 (2023), https://bit.ly/3TShwbQ.

[23] *See, e.g.*, Mary G. Findling et al., *Discrimination in the United States: Experiences of Native Americans*, 54 Health Serv. Res. 1431 (2019), https://bit.ly/4cyREc0; Mary Findling et al., *Discrimination in the United States: Experiences of Latinos*, 54 Health Serv. Res. 1409 (2019), https://bit.ly/3TPNd5r; Caitlin L. McMurty et al., *Discrimination in the United States: Experiences of Asian Americans*, 54 Health Serv. Res. 1419 (2019), https://bit.ly/3VB5KUi; Caroline Medina et al., *Protecting and Advancing Health Care for Transgender Adult Communities*, Ctr. for Am. Progress at 16 (Aug. 2021), https://ampr.gs/3PATZti.

[24] *See* Katherine Gallagher Robbins et al., *State Abortion Bans Threaten 6.7 Million Latinas*, Nat'l P'ship for Women & Families (Oct. 2023), https://bit.ly/3VtiA79.

[25] *Nowhere To Go: Maternity Care Deserts Across the U.S.*, March of Dimes at 5 (2022), https://bit.ly/4abk5LQ.

[26] *Id.* at 9.

higher odds of lacking hospital obstetric services and are more likely to lose obstetric services over time.[27] And over 80% of people living in rural Indigenous communities lack close access to a hospital-based obstetric unit.[28] The result is that one in four Indigenous babies, and one in six Black babies, are born in areas of limited or no access to pregnancy-related care.[29]

Woven together, these and other barriers to healthcare make pregnancies in certain communities particularly dangerous. For example, Black and Indigenous people have substantially higher rates of hypertension and diabetes than white people.[30] As explained below, these chronic conditions, coupled with limited access to routine prenatal care, lead to substantial disparities in pregnancy complications, including emergency complications. Without EMTALA's protections,

---

[27] Peiyin Hung et al., *Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14*, 36 Health Affairs 1663 (2017), https://bit.ly/3Tu6t7f.

[28] Peiyin Hung et al., *Spatial access to hospital-based obstetric units in minorized racial/ethnic areas*, Rural & Minority Health Rsch. Ctr. at 7 (Aug. 2022), https://bit.ly/3TpACVa.

[29] *Id.* at 6.

[30] *Heart Disease and African Americans*, U.S. Dep't of Health & Hum. Servs., https://bit.ly/3TwBqro (last accessed Mar. 25, 2024); *Diabetes and African Americans*, U.S. Dep't of Health & Hum. Servs., https://bit.ly/4980WsF (last accessed Mar. 25, 2024); *Heart disease, diabetes rates higher for American Indians, Alaska Natives*, Am. Heart Ass'n News (May 28, 2020), https://bit.ly/49addwI; *Indian Health Disparities*, Indian Health Servs. (Oct. 2019), https://bit.ly/3TRnU32.

these patients would face greater risks of severe illness and pregnancy-related death.

B. The United States is Battling a Maternal Health Crisis that Disproportionately Harms People in Communities that Face Systemic Oppression and Disinvestment.

The United States is in the throes of a maternal health crisis. Rates of pregnancy-related death are significantly higher in this country than in other high-income countries. And while maternal death is unacceptably common across all demographic groups, pregnancy is deadliest for nonwhite women, particularly Black and Indigenous women. Nonwhite women are also more likely to experience severe but survivable pregnancy complications that cause lasting damage to their lives and health. Early data suggest that state abortion bans are only fueling pregnancy-related death and disability.

Maternal Mortality. The risk of pregnancy-related death in the United States is up to *ten times higher* than in other high-income countries.[31] More alarmingly, over the last twenty years, maternal mortality

---

[31] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, The Commonwealth Fund (Nov. 18, 2020), https://bit.ly/4co1vRY.

rates in this country have climbed, while falling elsewhere.[32]

Study after study underscores that Black and Indigenous communities bear the brunt of this crisis. Black women are roughly three times more likely than white women to die a pregnancy-related death in the United States, and Indigenous women are more than twice as likely.[33] Worse still, pregnancy-related mortality rates for Black and Indigenous women over twenty-nine years old are *four to five* times that of their white counterparts.[34] These racial disparities persist *across* the socioeconomic spectrum. A recent study found "essentially no convergence in [maternal health] outcomes across racial groups as income increases," especially between Black and white women.[35] In other

---

[32] Eugene Declercq and Laurie C. Zephyrin, *Maternal Mortality in the United States: A Primer*, The Commonwealth Fund (Dec. 16, 2020), https://bit.ly/495tpiU.

[33] Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016*, 68 MMWR Morbidity & Mortal Weekly Rep. 762 (2019), https://bit.ly/3xcco9z; *see also* Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JAMA 52 (2023), https://bit.ly/43xMBoa.

Recent data also shows an increase in maternal mortality for Latinx individuals and high rates of maternal mortality during hospitalization for delivery among AAPI women. Maryam Siddiqui et al., *Increased Perinatal Morbidity and Mortality Among Asian American and Pacific Islander Women in the United States*, 124 Anesth. & Analg. 879 (2017), https://bit.ly/3ITRP4e.

[34] Petersen, *supra* note 33.

[35] Kate Kennedy-Moulton et al., *Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data* 5

words, greater education and wealth do not protect Black people from pregnancy-related death. The risks are heightened for Black and Indigenous people in rural areas, where pregnant people face a higher risk of intensive care unit admission and mortality than their counterparts in urban areas.[36]

Pregnancy-Related Emergencies and Complications. Maternal mortality is the tip of the iceberg: Maternal morbidity, or severe pregnancy complications, are also at crisis levels.[37] For every maternal death in the United States, there are at least seventy to eighty cases of severe maternal illness,[38] and that number is steadily increasing.[39]

Again, communities of color are hit hardest. Black and Indigenous women experience severe maternal morbidity—sometimes called "near misses"—roughly

---

(Nat'l Bureau of Econ. Rsch., Working Paper No. 30693, 2023), https://bit.ly/3ISnJOv.

[36] Katharine A. Harrington et al., *Rural-Urban Disparities in Adverse Maternal Outcomes in the United States, 2016-2019*, 113 Am. J. Pub. Health 224 (2023), https://bit.ly/49d5oGL; *see also* Katy B. Kozhimannil et al., *Severe Maternal Morbidity and Mortality Among Indigenous Women in the United States*, 135 Obstet. Gynecol. 294 (2020), https://bit.ly/3TMKwBz.

[37] Megan E. Deichen Hansen et al., *Racial Inequities in Emergency Department Wait Times for Pregnancy-related Concerns*, 18 Women's Health (2022), https://bit.ly/3TQlem0.

[38] Eugene Declercq and Laurie C. Zephyrin, *Severe Maternal Morbidity in the United States: A Primer*, The Commonwealth Fund (Oct. 28, 2021), https://bit.ly/43xkw0d.

[39] *Severe Maternal Morbidity*, Ctrs. for Disease Control & Prevention (last reviewed July 3, 2023), https://bit.ly/4996uTW.

twice as often as white women.[40] Compared to their white peers, Black women are more likely to suffer from hypertension, preterm labor, hemorrhage, and infection during or related to pregnancy,[41] and Latinas are at greater risk for gestational diabetes, peripartum infection, and postpartum hemorrhage.[42] Geography exacerbates these problems. Indigenous women in rural areas have a "substantially elevated risk" of serious complications during childbirth, as compared to white women and those living in urban areas.[43] The risk factors for complications among these groups have only increased over time.[44]

Abortion Restrictions Are Fueling the Crisis. Even before *Dobbs*, states that restricted abortion had higher maternal mortality rates than states that did not.[45] In 2020, maternal death rates were 62% higher

---

[40] Latina and AAPI women also suffer higher rates of severe morbidity than their white counterparts. Andreea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 Am. J. Obstet. Gynecol. 435.e1 (2014), https://bit.ly/3xic1dj.

[41] *See, e.g.*, Eran Bornstein et al., *Racial Disparity in Pregnancy Risks and Complications in the US: Temporal Changes during 2007-2018*, 9 J. Clin. Med. 1414 (2020), https://bit.ly/3ISvrIA (collecting studies).

[42] *Id.* (collecting studies).

[43] Katy B. Kozhimannil, *Indigenous Maternal Health—A Crisis Demanding Attention*, 1 JAMA Health Forum (2020), https://bit.ly/3PABqFA.

[44] Bornstein, *supra* note 41.

[45] Amy N. Addante et al., *The Association Between State-level Abortion Restrictions and Maternal Mortality in the United States, 1995-2017*, 104 Contraception 496 (2021), https://bit.ly/4aeDHPe.

in "abortion-restriction" states than in "abortion-access" states, and between 2018 and 2020, the maternal mortality rate increased nearly twice as fast in states with abortion restrictions.[46] Post *Dobbs*, researchers estimate that total abortion bans could cause a nearly 25% increase in maternal mortality overall, and a nearly 40% increase among Black people.[47] Like other structural barriers to life- and health-saving medical care, state abortion bans take a particularly heavy toll on Black and Indigenous women, who are the most likely to live in states that ban or are likely to ban abortion.[48]

C. Nullifying EMTALA's Mandate to Protect Pregnant Patients Will Further Harm At-Risk Communities.

As state abortion bans proliferate and protections for pregnant patients dwindle, EMTALA serves as a crucial bulwark against some of the worst consequences of the United States' maternal health crisis. If patients with emergency pregnancy complications can find their way to a Medicare-funded hospital, EMTALA requires that they receive the stabilizing

---

[46] Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, The Commonwealth Fund (Dec. 14, 2022), https://bit.ly/4a343U2.

[47] Amanda Jean Stevenson et al., *The maternal mortality consequences of losing abortion access*, University of Colorado Boulder at 8 (June 29, 2022), https://bit.ly/3VAhLcQ.

[48] Katherine Gallagher Robbins et al., *State Abortion Bans Harm More than 15 Million Women of Color*, Nat'l P'ship for Women & Families (June 2023), https://bit.ly/3ITRAWK.

care they need. If the Court removes that protection, patients will suffer and die at higher rates. Patients from communities pushed to the margins, who disproportionately visit hospital emergency departments, will experience the worst outcomes.

A holding that EMTALA does not preempt state abortion bans would also exacerbate maternity care deserts, making even routine obstetric care harder to find. In the wake of *Dobbs*, providers are moving away from states where abortion restrictions curtail their ability to provide emergency care. If the Court adopts Idaho's novel and dangerous interpretation of EMTALA, providers may leave at an even faster clip.

1. Stripping EMTALA's Protections from Pregnant Patients Will Worsen Outcomes for Pregnant Patients with EMCs.

Without EMTALA's protections, patients who need emergency abortion care that is impermissible under state law would have to: (1) travel out of state for treatment—an option that is not medically or financially viable for many patients; or (2) accept substandard treatment from an in-state hospital. Stories from hospitals that have violated EMTALA illustrate the horrific consequences of placing pregnant people in this bind.

Since *Dobbs*, there have been at least seventy public cases in which women with serious pregnancy complications were denied abortion care or had treatment

delayed due to a state abortion ban; the true number of cases is likely significantly higher.[49] One of these patients experienced PPROM before her fetus was viable. As explained above, *supra* Part I.A, the stabilizing treatment for pre-viable PPROM may be terminating a patient's pregnancy, either through an induction of labor or a dilation and evacuation (D&E)—a routine procedure. But this patient was sent home without that care. She returned to the emergency room two days later with severe sepsis and bacteremia. Her pre-viable fetus was delivered, but clinicians could not deliver her placenta. Eventually, a physician performed a D&E, but unlike healthy patients, this woman bled "from everywhere." The patient miraculously lived, but after her gut-wrenching experience, the concern she expressed to her doctor was whether her severe infection "count[ed] as life threatening," or whether she and her doctor would "go to jail" for the procedure that saved her life.[50]

Another patient in an abortion ban state sought treatment for a dilated cervix, through which her amniotic sac was protruding, when she was nineteen to twenty weeks pregnant. She was sent home. The following day, she came to the emergency department in severe pain and advanced labor. While EMTALA requires stabilizing treatment for pain, 42 U.S.C.

---

[49] Kavitha Surana, *Some Republicans Were Willing to Compromise on Abortion Ban Exceptions. Activists Made Sure They Didn't*, ProPublica (Nov. 27, 2023 5:00 AM), https://bit.ly/3VAhCGk.

[50] Grossman, *supra* note 9, at 7.

§ 1395dd(e)(1)(A), and stabilizing care during labor, 42 U.S.C. § 1395dd(e)(1)(B), the hospital's anesthesiologists *refused to provide an epidural*. As the patient's physician described:

> [The anesthesiologists] believed that providing an epidural could be considered [a crime] under the new [state] law. The patient received some IV morphine instead and delivered a few hours later but was very uncomfortable through the remainder of her labor. . . . I overheard the primary provider say to a nurse that so much as offering a helping hand to a patient getting onto the gurney while in the throes of a miscarriage could be construed as 'aiding and abetting an abortion.' Best not to so much as touch the patient who is miscarrying. . . .[51]

Denials of emergency abortion care can have severe and immediate consequences, including hemorrhage, infection, and, in the gravest cases, death. In the long-term, patients denied emergency abortions are susceptible to other health traumas, such as loss of fertility, chronic pelvic pain, and heart attack and stroke.[52]

Families are also burdened financially by denials of emergency abortions. When local hospitals turn pregnant patients away, those patients must bear the financial brunt of traveling to obtain emergency treatment, or else forgo the treatment they need. Either

---

[51] *Id.* at 8.

[52] *Id.* at 17.

option can have devastating consequences for the patients and their families. Pregnant patients with low-incomes may rely on every dollar to cover their basic living needs, making the cost of traveling out of state for healthcare incredibly burdensome.[53] But without emergency abortion care, patients may die or develop lasting disabilities. Two stories illustrate this plight.

Mylissa Farmer was denied the emergency abortion care she needed, first by her local hospital in Missouri, and then by a hospital in Kansas.[54] After diagnosing her with PPROM, doctors at both hospitals told Mylissa her fetus could not survive, and continuing her pregnancy would put her at risk of serious infection, hemorrhaging, the loss of her uterus, and even death.[55] Still, both hospitals refused to end the pregnancy, in violation of EMTALA.[56] With her health deteriorating rapidly, Mylissa and her boyfriend drove more than four hours to an Illinois abortion clinic *while*

---

[53] Furthermore, patients who develop long-term medical complications from denials of emergency abortion care must stretch their wages to cover ongoing medical treatment or else forgo the treatment they need—a position that Black and brown women are more likely to face. *Support for Maternal Health Policies Will Not Solve the Crisis in Abortion Access*, Nat'l Women's Law Ctr. (Apr. 2023), https://bit.ly/4co27XM.

[54] *Administrative Compl.*, U.S. Dep't of Health & Human Servs. Ctrs. For Medicare & Medicaid Servs. Headquarters at 12-13, 16 (Nov. 8, 2022), https://bit.ly/4ctlXkx.

[55] *Id.* at 11.

[56] *Id.* at 12-13, 16; *NWLC Files EMTALA and Sex Discrimination Complaints on Behalf of Mylissa Farmer*, Nat'l Women's Law Ctr. (Nov. 8, 2022), https://bit.ly/3PABRQe.

she was in labor.[57] The medical and financial consequences of crisscrossing state lines to obtain lifesaving abortion care linger to this day. Mylissa was docked pay for missing work and had to raise funds to pay for the Illinois care that her insurance refused to cover. Her boyfriend also lost his job because he was forced to miss work over the days he helped her travel. They could not regain steady employment for months.[58]

While Mylissa was ultimately able to obtain the care she needed, other patients have died after hospitals failed to offer stabilizing abortion care. For example, a young woman named Yeniifer (Yeni) Alvarez died from pregnancy complications in Texas. Experts agree that Yeni's death likely could have been prevented with an abortion, but hospital records show that, despite multiple emergency room visits (including one where she was struggling to breathe), healthcare providers never offered to end her pregnancy.[59] Yeni lived in an immigrant community in Luling, Texas, where 65% of residents lack health insurance—Yeni included.[60] She learned she had hypertension and diabetes during her pregnancy, and developed pulmonary edema at the height of the COVID-19 pandemic.[61] Because she was uninsured, she was unable to afford the

---

[57] *Id.* at 18.

[58] *Id.* at 19-20.

[59] Stephania Taladrid, *Did An Abortion Ban Cost A Young Texas Woman Her Life?*, The New Yorker (Jan. 8, 2024), https://bit.ly/3TRoLkg.

[60] *Id.*

[61] *Id.*

care and medications needed.[62] As her condition deteriorated, she went to the emergency room multiple times, but doctors did not offer abortion care.[63] Yeni's death represents what the lack of access to healthcare can mean for a pregnant person marginalized by lack of health insurance, poverty, and a draconian abortion ban. As Yeni's family mourn her preventable death, her loss has led to serious financial and familial hardship because Yeni contributed to the mortgage payments and was a frequent caregiver for a cousin and an autistic sibling.[64]

Unless this Court clarifies that EMTALA protects access to all emergency medical treatment, including emergency abortion care, stories like Mylissa's and Yeni's will become even more common.

2. Stripping Pregnant Patients of EMTALA's Protections Will Drive Healthcare Professionals Out of Abortion Ban States, Deteriorating Reproductive Care for *All* Pregnant Patients.

A decision that EMTALA no longer protects patients experiencing emergency pregnancy complications would diminish access to *all* obstetric and gynecological care in states with abortion bans. In the wake of *Dobbs*, healthcare professionals in abortion-ban states

---

[62] *Id.*

[63] *Id.*

[64] *Id.*

fear that providing medically necessary emergency obstetric care (including care required by EMTALA) may invite criminal prosecution, among other severe consequences. This fear is driving providers out of already underserved areas.[65] Idaho, for instance, lost 22% of its practicing obstetricians, and 55% of its high-risk obstetricians, in the fifteen months after the state's abortion bans went into place.[66] As one OBGYN, who left Idaho for Colorado, explained: "I was always one of those people who had been super calm in emergencies. . . . [ ]But I was finding that I felt very anxious being on the labor unit. . . . That's not how you want to go to work every day."[67]

Beyond immediate attrition, there is also mounting concern that the future pipeline of qualified OBGYN, maternal-fetal medicine physicians, and emergency room doctors will dry up,[68] as fewer medical

---

[65] *See, e.g.*, Shefali Luthra, '*We're not going to win that fight': Bans on abortion and gender-affirming care are driving doctors from Texas*, The 19th (June 21, 2023, 10:33 AM), https://bit.ly/4csSuar; Cole Sullivan, *Doctor leaves Tennessee for Colorado over abortion ban*, 9 News (Apr. 7, 2023, 5:00 AM), https://bit.ly/3xaV0BW.

[66] *A Post* Roe *Idaho*, Idaho Physician Well-Being Action Collaborative & Idaho Coal. For Safe Healthcare at 3, 5 (Feb. 2024), https://bit.ly/3VsD2VH.

[67] Sheryl Gay Stolberg, *As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers*, The New York Times (Sept. 7, 2023), https://nyti.ms/3VyR9IV.

[68] Elizabeth Tobin-Tyler et al., *A Year After* Dobbs: *Diminishing Access to Obstetric-Gynecologic and Maternal-Fetal Care*, Health Affairs (Aug. 3, 2023), https://bit.ly/43wvNOq.

students seek to practice in abortion ban states,[69] and abortion restrictions limit OBGYN training[70] and reduce non-OBGYN physicians' capacity to respond to obstetric emergencies.[71]

Physician "exodus"[72] from abortion ban states is leading to the closure of reproductive health facilities, especially in rural areas. At least two hospitals in Idaho shuttered their labor and delivery units in 2023, with more to come,[73] and one of those hospitals, Bonner General Health, cited the departure of "highly respected, talented physicians" due to the state's "legal and political climate" as one of the main reasons for its decision.[74] Given that Black and Indigenous pregnant patients are already most likely to suffer the harms of maternity care deserts in rural areas, *supra* Part II.A, these closures will further devastate patients from those communities.

---

[69] *See, e.g.*, Kendal Orgera et al., *Training Location Preferences of U.S. Medical School Graduates Post* Dobbs v. Jackson Women's Health, Ass'n of Am. Med. Colleges Rsch. & Action Inst. (Apr. 13, 2023), https://bit.ly/3Tvv7o4.

[70] Rachel Rabkin Peachman, Dobbs *Decision Threatens Full Breadth of Ob-Gyn Training*, 328 JAMA 1668 (2022), https://bit.ly/3Ty4bUH.

[71] Stephanie J. Lambert et al., *Impact of the* Dobbs *Decision on Medical Education and Training in Abortion Care*, 33 Women's Health Issues 337 (2023), https://bit.ly/4atIlZm. *See also* Stolberg, *supra* note 67.

[72] Julie Rovner, *Abortion bans drive off doctors and close clinics, putting other health care at risk*, OBP (May 23, 2023 9:28 AM), https://bit.ly/3IYBKtT.

[73] *A Post* Roe *Idaho*, *supra* note 66, at 3.

[74] Stolberg, *supra* note 67.

If this Court were to hold that EMTALA does not cover pregnant patients as it covers all other patients, medical professionals would have one less layer of protection as they make profound decisions in the emergency room. As a result, doctors capable of providing a range of obstetric and gynecological care—from urgent care to life-saving cancer screenings—will continue to flee. With fewer providers, *all* pregnant people, especially Black and Indigenous people, will suffer lifechanging harms, and many will die preventable deaths.

CONCLUSION

Amici Curiae respectfully urge the Court to hold that EMTALA protects access to emergency abortion care—a holding required by the plain text of the statute and necessary to prevent grave harm to communities that face systemic oppression and disinvestment.

Respectfully submitted,

MICHELLE BANKER
GRETCHEN BORCHELT
DORIANNE MASON
LEILA ABOLFAZLI
LEXI RUMMEL
DONYA KHADEM
KENNA TITUS
NATIONAL WOMEN'S LAW CENTER
1350 I St. NW, Ste. 700
Washington, DC 20005
Tel: (202) 588-5180
mbanker@nwlc.org

March 28, 2024

CHRISTINE E. WEBBER
Counsel of Record
ALISON S. DEICH
ANIKO R. SCHWARCZ
HARINI SRINIVANSAN
NINA C. JAFFE-GEFFNER
SABRINA S. MEROLD
ANN SIMONE NISSENBAUM SARNAK
COHEN MILSTEIN SELLERS & TOLL PLLC
1100 New York Ave. NW, Ste. 500
Washington, DC 20005
Tel: (202) 408-4600
Fax: (202) 408-4699
cwebber@cohenmilstein.com
adeich@cohenmilstein.com

Counsel for Amici Curiae

APPENDIX

APPENDIX TABLE OF CONTENTS

APPENDIX

Abortion Care Network

AccessMatters

All* Above All

American Atheists

American College of Nurse-Midwives

American Federation of State, County and Municipal Employees, AFL-CIO

American Federation of Teachers

American Humanist Association

American Society for Reproductive Medicine

Americans United for Separation of Church and State

Asian & Pacific Islander American Health Forum (APIAHF)

Avow Texas

Bans Off Miami

Birth In Color

Black Women for Wellness

California Women's Law Center

Catholics for Choice

Center for Inquiry

Central Conference of American Rabbis

Community Catalyst

DC Abortion Fund

Disability Policy Consortium

Equality California

Feminist Women's Health Center

FL National Organization for Women (FL NOW)

Florida Interfaith Coalition for Reproductive Health and Justice, Inc.

Freedom From Religion Foundation

Gender Justice

Greater Orlando National Organization for Women (Greater Orlando NOW)

Guttmacher Institute

Hadassah, The Women's Zionist Organization of America

Hispanic Federation

Human Rights Campaign Foundation

Ibis Reproductive Health

Indigenous Idaho Alliance

Indivisible

Indivisible Action Tampa Bay

Indivisible Pro-Choice Pinellas

Jacobs Institute of Women's Health

Jane's Due Process

Justice and Joy National Collaborative (formerly National Crittenton)

Lawyers for Good Government

League of Women Voters of the United States

Legal Action Center

Legal Momentum

Lift Louisiana

Mabel Wadsworth Center

Men of Reform Judaism

Montanans for Choice

Mothering Justice

Muslim Women's Organization

NAACP Legal Defense & Educational Fund, Inc.

National Abortion Federation

National Asian Pacific American Bar Association

National Association of Commissions for Women

National Center for Lesbian Rights

National Council of Jewish Women

National Education Association

National Family Planning & Reproductive Health Association

National LGBTQ Task Force

National Partnership for Women & Families

National Women's Health Network

National Women's Political Caucus

New Jersey Association of Women Lawyers

People For the American Way Foundation

People Power United

Planned Parenthood Federation of America

Power to Decide

Pro-Choice North Carolina

Pro-Choice Wyoming

Progress Florida

Public Advocacy for Kids (PAK)

Rapid Benefits Group Fund

Reproaction

Reproductive Equity Now

Reproductive Freedom for All (formerly NARAL Pro-Choice America)

Reproductive Health Access Project

Service Employees International Union (SEIU)

SIECUS: Sex Ed for Social Change

SisterReach Illinois

SisterReach, Inc.

Southwest Women's Law Center

State Innovation Exchange (SIX)

The Century Foundation

The Jane Network

The Leadership Conference on Civil and Human Rights

The National Association of Nurse Practitioners in Women's Health (NPWH)

The Women's Emergency Network

The Womxn Project

Trust Women Foundation

UCSF Bixby Center for Global Reproductive Health

Union for Reform Judaism
URGE: Unite for Reproductive & Gender Equity
Women Lawyers On Guard Inc.
Women of Reform Judaism
Women with a Vision
Women's Law Center of Maryland
YWCA USA