Case Nos. 23-35440, 23-35450

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiffs/Appellants,
v.

STATE OF IDAHO,
Defendants/Appellees.
v.

MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE, Proposed Intervenor-Defendants,
Movants-Appellants

On Appeal from the United States District Court
for the District of Idaho
No. 1:22-cv-00329-BLW
Honorable B. Lynn Winmill, District Court Judge

BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND OTHER DISABILITY RIGHTS ORGANIZATIONS AND EXPERTS AS AMICI CURIAE IN SUPPORT OF APPELLEE

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1. The Autistic Self Advocacy Network
2. Autistic Women & Nonbinary Network
3. The Bazelon Center for Mental Health Law
4. Disability Law United
5. Disability Rights Advocates
6. Disability Rights California
7. Disability Rights Education and Defense Fund
8. Disability Rights Oregon
9. Disability Rights Washington
10. Legal Voice
11. The National Council on Independent Living
12. National Health Law Program
13. Women Enabled International
14. Katherine Pérez, J.D., Ph.D.
15. Robyn Powell, Ph.D., J.D.
16. Ruth Colker, J.D.
17. Honorable Tony Coelho

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, counsel for *Amici Curiae* certifies that no *Amici* has a parent corporation and that no publicly held corporation owns 10 percent or more of any *Amici*'s respective stock.

CONSENT OF THE PARTIES TO THE FILING PURSUANT TO FEDERAL RULE OF APPELLATE PROCEDURE 29(A)(2)

This motion is filed with the consent of The United States, counsel for Plaintiffs-Appellees, Alan Hurst, counsel for Defendant-Appellant State of Idaho, and Taylor Meehan, counsel for Defendants-Appellants Mike Moyle, the Sixty Seventh Idaho Legislature, and Chuck Winder.

STATEMENT PURSUANT TO FEDERAL RULE OF APPELLATE PROCEDURE 29(A)(4)(E)

The undersigned certifies that no party's counsel authored this brief in whole or in part, and that no party, party's counsel, or any other person other than *Amici*, their members, or their counsel, contributed money that was intended to fund preparing or submitting this brief.

IDENTITY AND INTERESTS OF *AMICI*

Amici are non-profit disability rights and reproductive justice organizations and disability rights experts. For decades, they have engaged in legal advocacy, training, education, legislative drafting and public policy development to protect and advance the civil rights of people with disabilities. Collectively and

individually, *Amici* have a strong interest in ensuring that Idahoans with disabilities, and all disabled people living in states with similar near-total abortion bans, have access to emergency treatment, including abortion care. Individual *Amici* are described in more detail in the attached addendum.

INTRODUCTION

This case centers on whether the federal Emergency Medical Treatment and Labor Act ("EMTALA") preempts Idaho Code § 18-622, a state abortion ban. The answer is yes. Idaho Code § 18-622, termed a "total abortion ban" by the Idaho Supreme Court, denies patients the stabilizing abortion care necessary to prevent serious harm if their condition is not life-threatening. *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1147 (Idaho 2023). By contrast, EMTALA requires hospitals that receive Medicare funds to provide stabilizing care, including abortion care, when an emergency condition threatens a pregnant patient's health, even if that condition stops short of threatening their life. In short, EMTALA requires care that Idaho Code § 18-622 prohibits, and federal law must take precedence to ensure that people can access the emergency care they need. *See* U.S. CONST. art. VI, cl. 2.

Idaho Code § 18-622 also frustrates EMTALA's purpose by denying at-risk people the medical care necessary to stabilize them and prevent harm if their emergency condition is not life-threatening. Congress enacted EMTALA to ensure

that those least likely to have access to medical care, including people with disabilities, receive the care they need during an emergency.

Disabled people face substantial barriers to medical care which make it significantly more likely that they will need the emergency stabilizing abortion care prohibited by Idaho's ban. If this Court vacates the district court's preliminary injunction, the medical system will continue to be undermined in ways that disproportionately harm disabled people. *Amici* therefore urge this Court to affirm the district court's order and preserve EMTALA's promise to protect people most at risk of being denied necessary stabilizing treatment during emergency situations.

ARGUMENT

I. IDAHO CODE § 18-622 DIRECTLY CONFLICTS WITH EMTALA.

Idaho Code § 18-622 and EMTALA directly conflict. When a pregnant patient presents at a hospital with an emergency condition for which abortion is the necessary stabilizing treatment, § 18-622 prohibits that abortion unless the patient is at risk of death. By contrast, EMTALA requires hospitals that receive Medicare funds to stabilize any patient whose health is at risk—including through abortion care when necessary—even if the emergency condition does not threaten the patient's life. It is impossible for medical providers to comply with both the state statute and federal law when an abortion is the necessary stabilizing treatment for an emergency condition that threatens a pregnant patient's health, bodily functions,

or organ functions, but not their life. This conflict creates an impossible situation for doctors at the expense of their patients, especially those with disabilities.

Idaho Code § 18-622 permits emergency stabilizing abortion care only when it is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a)(i).[1] Appellants have maintained throughout the course of this litigation that *only a threat of death* can justify an emergency abortion under Idaho Code § 18-622. *See* Tr. of Oral Arg., *Moyle v. United States,* 144 S. Ct. 2015 (2024) at 23, 25–28, 33–34,

Idaho Code § 18-622 directly conflicts with EMTALA's requirement that hospitals provide stabilizing abortion treatment in situations beyond those in which a pregnant person is at risk of death. EMTALA states, "[i]f any individual . . . has an emergency medical condition, the hospital must provide either . . . such treatment as may be required to stabilize the medical condition, or . . . transfer of the individual to another medical facility" that can provide such stabilizing care. 42 U.S.C. § 1395dd(b)(1). EMTALA requires stabilizing treatment where there is a condition that could "reasonably be expected" to result in: (i) the "health" of the person being put in "serious jeopardy," (ii) "serious impairment to bodily functions," or (iii) "serious dysfunction of any bodily organ or part." 42 U.S.C. §

[1] The ban also allows abortion in certain pregnancies resulting from rape or incest, but these exceptions are not at issue here. *See* Idaho Code § 18-622(2)(b).

1395dd(e)(1)(A). This stabilizing care must be "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result" from transfer or discharge. 42 U.S.C. §1395dd(e)(3)(A).

The text of both statutes is plain. Idaho Code § 18-622 directly conflicts with EMTALA because it prohibits abortion unless it is necessary to prevent death, and EMTALA requires an emergency abortion where a pregnant person's health, bodily functions, or organ functions are in jeopardy. *See Moyle v. United States*, 144 S. Ct. 2015, 2016 (2024) (stabilizing care required under EMTALA includes "abortions necessary to prevent grave harms to the woman's health, like the loss of her fertility.") (Kagan, J., concurring). At the center of this conflict are pregnant people who experience emergency medical conditions that pose a grave threat to their health, but who are not at risk of death. For pregnant people with PPROM, placental abruption, pre-eclampsia, eclampsia, spontaneous miscarriage with detectable fetal heart rate, or intrauterine infection, pregnancy termination may be necessary to prevent harm to the patient's health, bodily functions, or organ functions. *See* Appellees' Br. 16, ECF No. 192 (citing to physician declarations). Continuing a pregnancy after such conditions develop can result in several consequences short of death: loss of fertility; hysterectomy; sepsis; clotting disorder; heart attack; coma; stroke; cardiovascular, immune or platelet dysfunction; and renal, liver or other organ failure. *See Id.* Under § 18-622,

medical providers are prohibited from providing essential emergency abortion care to patients experiencing these health threatening complications if the patient is not at risk of death.

As this brief describes in more detail in Section III(B), *infra*, pregnant people with disabilities are disproportionately likely to fall into the care gap created by Idaho's abortion ban because they are at significantly increased risk for adverse pregnancy outcomes.[2] Furthermore, pregnant people with certain disabilities may also experience a higher risk to their organs or health during pregnancy because of the way their disabilities interact with pregnancy, or the need to discontinue disability-related medications during pregnancy. These realities make access to emergency stabilizing abortion care essential for people with disabilities.

Additionally, as discussed in Section II, *infra*, in enacting EMTALA, Congress sought to protect people from being denied care, especially disabled people and other marginalized groups, by ensuring that hospitals provide stabilizing treatment for all patients in emergency situations. Yet, Idaho Code § 18-622 subjects providers to criminal penalties and loss of license for providing essential, health-preserving treatment. It is because of this direct conflict that the

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[2] See Jessica Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, J. AM. MED. ASS'N NETWORK OPEN, Dec. 15, 2021, at 2, 4–7.

district court's denial of Appellants' motion for reconsideration of the preliminary injunction was justified and should be upheld. *United States v. Idaho*, 623 F. Supp. 3d 1096, 1109 (D. Idaho 2022), *reconsideration denied*.

II. CONGRESS ENACTED EMTALA TO ENSURE THAT AT-RISK PEOPLE—INCLUDING DISABLED PEOPLE—RECEIVE EMERGENCY STABILIZING MEDICAL TREATMENT.

EMTALA requires that hospitals receiving Medicare funding provide emergency stabilizing medical care for all emergency room patients. When Congress passed EMTALA, it sought to protect emergency care access for those most in need and least able to access it, including disabled people. Indeed, EMTALA is not the only expression of Congress' intent in this regard; the law fits within a series of federal statutes reflecting a congressional desire to protect the rights of disabled people in the healthcare context. Idaho Code § 18-622 frustrates Congress' purpose in enacting these federal protections.

A. In Enacting EMTALA, Congress Sought to Protect At-Risk People, Including People with Disabilities.

Congress passed EMTALA in 1986, in response to pervasive disparities in emergency room treatment—particularly "patient dumping," the practice of refusing care to patients who needed it the most. *See* U.S. COMM'N ON CIVIL RIGHTS, STATUTORY ENFORCEMENT REPORT: PATIENT DUMPING 3–5 (2014). Congress' purpose in passing the law was to broadly guarantee the "provision of

adequate emergency room medical services to individuals who seek care" regardless of wealth, insurance status, or other classifications. H.R. Rep. No. 99-241, at 5 (1985).

In practice, this meant ensuring that "high quality emergency care" would be available "to all patients without discriminat[ion]." 131 Cong. Rec. 29,833 (1985) (statement of Rep. Bilirakis). Congress refused to "stand idly by and watch those Americans who lack the resources be shunted away from immediate and appropriate emergency care." 131 Cong. Rec. 28,568 (1985) (statement of Sen. Durenberger). It is clear from the legislative history that Congress did not simply enact EMTALA to prevent hospitals from denying any treatment after a condition has been identified as an emergency, as Appellants suggest. *See* App. Br. 37–38, ECF 129. Rather, Congress intended EMTALA to protect all patients, particularly those who might otherwise be denied high-quality emergency care based on economic status or other forms of discrimination.

There can be no doubt that Congress included people with disabilities among those it wished to protect through EMTALA. Disabled people are particularly likely to lack resources, to have complex health conditions, and to experience discrimination, and are thus among those most likely to need access to effective emergency care. Indeed, as one of the primary sponsors of EMTALA noted, disabled people are more likely to be "uninsured" or "indigent"—the very people

most in need of EMTALA's assurance of care. Views of Budget Proposals for Fiscal Year 1986: Hearings before the H. Comm. on Budget, 99th Cong. 375–76 (1985) (prepared statement of Rep. Waxman). The plain language of EMTALA "unambiguously requires that a Medicare funded hospital provide whatever medical treatment is necessary to stabilize a health emergency—and an abortion, in rare situations, is such a treatment." *Moyle*, 144 S. Ct. at 2018 (Kagan, J., concurring).

It was unnecessary for Congress to list all forms of medical treatment that EMTALA requires at its inception for the statute to clearly require that hospitals "provide emergency services to individuals with life-threatening or potentially crippling conditions," irrespective of the type of procedure. 131 Cong. Rec. 13,903 (1985) (statement of Sen. Durenberger). Abortion is part of the stabilizing treatment covered by EMTALA, and Congress intended to protect such care. *See, e.g.*, *New York v. United States HHS*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019) (citing 151 Cong. Rec. H177 (2005) (statement of Rep. Weldon)). As discussed in Section III(A), *infra*, people with disabilities experience higher risks and worse health outcomes during their pregnancies than non-disabled people, making their access to emergency stabilizing care under EMTALA all the more essential.

B. EMTALA Fits Within the Broader History of Congress' Efforts to Ensure Access to Healthcare for Disabled People, an At-Risk Group.

Congress has repeatedly sought to protect access to healthcare for people with disabilities. Section 504 of the Rehabilitation Act of 1973, enacted years before Congress passed EMTALA, prohibits discrimination against disabled people in programs that receive federal financial assistance, including healthcare programs. 29 U.S.C. § 794. Congress passed the landmark Americans with Disabilities Act ("ADA") in 1990, recognizing that "discrimination against individuals with disabilities persists in such critical areas as . . . health services," among others, and prohibiting such healthcare discrimination regardless of receipt of federal funding. 42 U.S.C. § 12101(a)(3); *see also* 42 U.S.C. § 12132; *see also* 42 U.S.C. §§ 12182(a), 12181(7)(F). More recently, the passage of the Patient Protection and Affordable Care Act ("ACA") marked a milestone in Congress' efforts to ensure equitable medical treatment for people with disabilities. The ACA specifically prohibits discrimination on the basis of disability and denial of health insurance coverage based on medical history or existing conditions for health programs and activities receiving federal financial assistance. *See* 42 U.S.C. § 18116 (a); *see also* 42 U.S.C. § 300gg–3; 45 C.F.R. §§ 147.104, 147.106, 147.108.

EMTALA represents one piece of this broader body of legislation, intended to protect access to emergency medical care for disabled people—including health-stabilizing abortions.

III. PERMITTING THE ENFORCEMENT OF IDAHO'S ABORTION BAN WOULD NEGATE EMTALA'S PROTECTIONS AND RESULT IN SERIOUS HARM TO IDAHOANS WITH DISABILITIES.

Pregnant people with disabilities are especially likely to suffer severe injuries or die without access to the emergency stabilizing abortion care that EMTALA guarantees. As described below, disabled people face substantial barriers to accessing primary and prenatal care, and without that care their risk of pregnancy complications rises. Disabled people are also more likely to need abortions as stabilizing care in an emergency setting, because they are more likely to have underlying conditions that may complicate pregnancy and are much more likely to experience adverse pregnancy outcomes. Allowing Idaho Code § 18-622 to strip patients of EMTALA's protections will increase barriers to care, causing pregnant people with disabilities to endure unnecessary trauma, injury, and possibly even death. These dire consequences directly conflict with the statutory language and with Congress' purpose in passing EMTALA: to protect at-risk people's access to stabilizing treatment in emergencies.

A. Disabled People Face Significant Barriers to Obtaining Medical Care.

Systemic barriers obstruct disabled people's access to medical care, increasing their need for EMTALA's protections. Accessible transportation is frequently unavailable, medical facilities are inaccessible and/or lack adaptive

equipment, and providers display anti-disability bias and lack training on how to treat and accommodate disabled people. Disabled people are also more likely to have limited resources and delay accessing medical care due to the expense. These barriers make it more likely that disabled people will not receive preventative and prenatal care, increasing the risk that they will experience an emergency condition that requires treatment protected by EMTALA.

A 2023 study found that fifty percent of women with disabilities have experienced logistical barriers to accessing reproductive healthcare.[3] One of the most significant of those barriers is transportation.[4] While the majority of Americans travel by personal vehicle, disabled people are less likely to drive and, accordingly, may opt to travel less. Many people with disabilities rely on others to drive them to their medical appointments.[5] As a result, their ability to obtain timely treatment often depends on the willingness and ability of others to assist with their

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[3] M. Antonia Biggs, PhD, et al., *Access to Reproductive Health Services Among People with Disabilities*, J. AM. MED. ASS'N NETWORK OPEN, Nov. 29, 2023, at 1. Although people of various gender identities can become pregnant, this study narrowly focused on disabled women, which is why we use that language here. The same is true where we refer to women in connection with studies cited elsewhere in this brief.

[4] *Id.;* Abigail L. Cochran et al., *Transportation Barriers to Care Among Frequent Health Care Users During the COVID Pandemic*, BMC PUB HEALTH, Sept. 20, 2022, at 7.

[5] Stephen Brumbaugh, *Travel Patterns of American Adults with Disabilities*, U.S. DEP'T OF TRANSP., 3–4, 7, 9 (Jan. 3, 2022), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf.

travel. Consequently, disabled people are significantly more likely to arrive late to medical appointments, miss appointments, or delay their care due to transportation difficulties.[6] Difficulties in coordinating travel leads many disabled people to forgo preventative treatment, increasing the likelihood that they will subsequently need emergency healthcare.

Even when a disabled person can get transportation to medical care, many healthcare facilities are inaccessible for people with physical disabilities because they lack accessible entrances, internal spaces, or restrooms. Across multiple studies, both physicians and people with disabilities report that, despite federal law requiring equal access to healthcare facilities, physical barriers remain.[7]

Despite recent rulemaking by the Department of Health and Human Services,[8] lack of adaptive medical equipment like adjustable height exam tables

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[6] Cochran, *supra,* at 7.
[7] See, e.g., Tara Lagu et al., *'I Am Not the Doctor For You': Physicians' Attitudes About Caring For People With Disabilities*, 41 HEALTH AFFAIRS 1387, 1389–90 (2022); NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 1, 49–51 (2009) [hereinafter THE CURRENT STATE]; Nancy R. Mudrick et al., *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews, Disability and Health*, 5 DISABILITY & HEALTH J. 159, 159 (2012) (finding that forty-four percent of gynecology offices surveyed would be unable to accommodate a wheelchair user, making it the most inaccessible subspecialty surveyed); Michael D. Stillman et al., *Healthcare Utilization and Associated Barriers Experienced by Wheelchair Users: A Pilot Study*, 10 DISABILITY & HEALTH J. 502, 508 (2017) (reporting that seventy-three percent of wheelchair users surveyed had experienced physical barriers to accessing primary care in the past year).
[8] *See* 45 C.F.R. Part 84, Subpart J (effective July 8, 2024).

and accessible scales to perform basic screening tests and procedures continues to be an issue. Some physicians have reported sending wheelchair users to a zoo, cattle processing plant, supermarket, or grain elevator in order to record their weights because they did not have an accessible scale.[9] The lack of accessible medical equipment means that many people with disabilities do not get common screening tests, resulting in delayed and incomplete care, missed diagnoses, exacerbation of the original disability, and increases in the likelihood of the development of secondary conditions.[10]

Economic barriers persist as well. People with disabilities are two times more likely to be poor and more likely to be unemployed than non-disabled people.[11] One study found that one-sixth of adults with disabilities needed, but did not receive, medical care in the prior twelve months because of the cost.[12] This is over three times the share of non-disabled people.[13] In Idaho, sixty-six percent of

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[9] *See* Lagu, *supra,* at 1389–90.
[10] NAT'L COUNCIL ON DISABILITY, ENFORCEABLE ACCESSIBLE MEDICAL EQUIPMENT STANDARDS: A NECESSARY MEANS TO ADDRESS THE HEALTH CARE NEEDS OF PEOPLE WITH MOBILITY DISABILITIES 7 (May 21, 2021).
[11] Pam Fessler, *Why Disability and Poverty Still Go Hand in Hand 25 Years After Landmark Law*, NAT'L PUB. RADIO, AT 3:38PM EST (July 23, 2015), https://www.npr.org/sections/health-shots/2015/07/23/424 990474/why-disability-and-poverty-still-go-hand-in-hand-25-years-after-landmark-law.
[12] NANETTE GOODMAN ET AL., NAT'L DISABILITY INST., FINANCIAL INEQUALITY: DISABILITY, RACE AND POVERTY IN AMERICA, 16 (2017), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf.
[13] *Id.* at 17.

disabled adults are not in the workforce, compared with just thirty-six percent of non-disabled adults; twenty-eight percent of disabled people aged sixteen or older in Idaho are below or within 150% of the poverty line, compared to eighteen percent of non-disabled Idahoans.[14] For these reasons, out of state travel to access emergency abortion care may be out of reach for many people with disabilities. In 2023 the average domestic air itinerary cost $380; that cost is likely higher for disabled people who require accommodations, such as wheelchair-accessible transportation to the airport.[15] Thirty-seven percent of American workers surveyed in 2022 reported that they would struggle to cover an unexpected $400 expense,[16] a rate that is likely much higher for pregnant people with disabilities. Lack of accessibility and other logistical challenges create additional barriers.[17]

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[14] *Selected Economic Characteristics for the Civilian Noninstitutionalized Population by Disability Status, American Community Survey*, U.S. CENSUS BUREAU, https://data.census.gov/table/ACSST1Y2021.S1811?q=civilian%20noninstitutionaliz ed&g=040XX00US16 (last visited Oct. 18, 2024).
[15] *Annual U.S. Domestic Average Itinerary Fare in Current and Constant Dollars*, U.S. BUREAU OF TRANSP. STAT., https://www.bts.gov/content/annual-us-domestic-average-itinerary-fare-current-and-constant-dollars (last visited Oct. 18, 2024).
[16] U.S. FED. RESERVE, ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2022 at 2 (2023), https://www.federal reserve.gov/publications/files/2022-report-economic-well-being-us-house holds-202305.pdf.
[17] Amanda Morris, *Embarrassing, Uncomfortable and Risky: What Flying is Like for Passengers Who Use Wheelchairs*, N.Y. TIMES (Aug. 8, 2022), https://www.nytimes.com/2022/08/08/ travel/air-travel-wheelchair.html (reporting the experience of a person with a disability and wheelchair user of being physically dropped by airline employees assisting him in transferring to his seat, being unable

Even if disabled pregnant people can overcome physical, logistical, and economic barriers to healthcare, many doctors are not sufficiently trained to work with people with disabilities. A 2022 survey of over 700 physicians revealed that less than half were confident they could provide similar quality of care to disabled patients as they could to those without disabilities.[18] Over thirty-five percent reported that a lack of training was a barrier to providing effective care to disabled people.[19] Studies suggest that as a result of insufficient training, providers make clinical decisions to avoid treating people with disabilities, further curtailing access to care.[20]

Many doctors also report having discriminatory views of disabled people, seeing them as "entitled" or prone to exaggeration.[21] Some reproductive health providers arbitrarily tell disabled women that pregnancy would be too dangerous for them, which is likely to discourage disabled people from seeking medical

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to use airplane restrooms, receiving no help with his checked luggage, and having to wait extended periods of time for assistance getting on and off the plane); see also Ned S. Levi, *Airlines Damage Passenger Wheelchairs–-More Than 200 a Week*, TRAVELERS UNITED (Aug. 7, 2023), https://www.travel ersunited.org/the-time-is-now-for-the-airlines-to-stop-damaging-so-many-passenger-wheelchairs/ (noting that in 2022, U.S. airlines reported 11,389 mishandled wheelchairs and scooters).

[18] Lisa I. Iezzoni et al., *What Practicing U.S. Physicians Know About the Americans with Disabilities Act and Accommodating Patients with Disability*, 41 HEALTH AFFAIRS 96, 101 (2022).

[19] *Id.*

[20] *See, e.g.,* Lagu, *supra,* at 1391–92.

[21] *Id.*

advice once they become pregnant.[22] Healthcare providers often do not ask people with disabilities about their reproductive health needs, because the providers "assume they are asexual, infertile, or simply incapable of having or consenting to sex."[23] Even though they are just as likely as non-disabled people to become pregnant, people with disabilities are less likely to receive sex education, contraception, and family planning services, in part because providers and caregivers do not view such services as necessary for disabled people.[24]

Patients who experience these barriers and discrimination are more likely to underutilize and delay medical care, including preventative and prenatal care that could be critical to prevent emergency pregnancy complications.[25]

B. Disabled People are More Likely to Need the Stabilizing Abortion Care Protected Under EMTALA But Banned by Idaho Code § 18-622.

Proper prenatal care allows early diagnosis and treatment of pregnancy

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[22] *See, e.g.*, Nat'l Council on Disability, Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children*,* 204–06 (2012).

[23] NICOLETTE WOLFREY, NAT'L P'SHIP FOR WOMEN & FAMILIES AND AUTISTIC SELF-ADVOC. NETWORK, ACCESS, AUTONOMY, AND DIGNITY: CONTRACEPTION FOR PEOPLE WITH DISABILITIES 13 (2021), https://nationalpartnership.org/wp-content/uploads/2023/ 02/repro-disability-contraception.pdf [hereinafter Access, Autonomy and Dignity].

[24] *See, e.g., id.;* Robyn M. Powell et al., *Role of Family Caregivers Regarding Sexual and Reproductive Health for Women and Girls with Intellectual Disability: A Scoping Review*, 64 J. INTELL. DISABILITY RSCH. 131, 132 (2020).

[25] *See, e.g.,* Laura VanPuymbrouck, *Explicit and Implicit Disability Attitudes of Healthcare Providers*, 65 REHABILITATION PSYCH. 101, 102–03 (2022).

complications,[26] but pregnant people with disabilities are less likely to receive timely and consistent prenatal care. One study found that women with intellectual disabilities are less likely to receive prenatal care in the first trimester compared to non-disabled pregnant people.[27] Additionally, certain disability-related chronic conditions are linked to irregular menstrual periods, making early pregnancy detection more difficult[28] and consequently hindering access to early prenatal care. These compounding barriers put pregnant people with disabilities at greater risk of having medically complicated pregnancies that are more likely to require the emergency stabilizing treatment that EMTALA is intended to protect, including abortion care.

Pregnancies can be especially challenging for people with disabilities who have pre-existing complex healthcare needs that put them at greater risk for pregnancy complications. In addition to the social factors that lead to complex pregnancies, medical interactions between pregnancy and disability increase the likelihood of pregnancy complications, making it more likely that people with

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[26] *See, e.g.,* Wendy Sword et al., *Women's and Care Providers' Perspectives of Quality Prenatal Care: A Qualitative Descriptive Study*, BMC PREGNANCY AND CHILDBIRTH, Apr. 13, 2012, at 1–2; Willi Horner-Johnson, et al., *Perinatal Health Risks and Outcomes Among U.S. Women With Self-Reported Disability, 2011-19*, 41 HEALTH AFF. 1477, 1483 (2022).
[27] Horner-Johnson, *supra*, at 1481.
[28] Jenna Nobles, *Menstrual Irregularity as a Biological Limit to Early Pregnancy Awareness*, 119 PROC. NAT'L ACAD. SCI., Jan. 4, 2021, at 1.

disabilities will require emergency abortions as stabilizing treatment. Pregnant people with physical, intellectual, and sensory disabilities face a "significantly higher risk of almost all adverse maternal outcomes" and are eleven times more likely to die during childbirth than non-disabled people.[29] Along with other pregnancy-related complications, pregnant people with disabilities are twenty-three times more likely to develop sepsis (a dangerous inflammatory response to an infection that can result in organ failure and death); six times more likely to develop thromboembolism (blood clots in the lungs or veins of the legs which can result in tissue damage and death); four times more likely to develop severe cardiovascular issues (including heart attacks and other disorders of the heart and blood vessels); nearly three times more likely to develop an infection; twenty-seven percent more likely to experience hemorrhaging (uncontrollable blood loss), which is one of the leading causes of maternal mortality; and twelve percent more likely to experience placental abruption (the separation of the placenta from the uterine wall before birth) during pregnancy.[30]

Notably, disabled pregnant people are more likely to experience severe preeclampsia or eclampsia (multi-system pregnancy disorders marked by high blood pressure) and PPROM during pregnancy.[31] Pregnant people with disabilities are

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[29] Gleason, *supra,* at 2, 4–7.
[30] *Id.*
[31] *Id.* at 4–7.

twice as likely as non-disabled people to develop severe preeclampsia/eclampsia during pregnancy,[32] which can result in seizures, destruction of red blood cells, low platelet count, kidney or liver damage or failure, and stroke,[33] thus increasing the likelihood of placental abruption and hemorrhage.[34] Placental abruption and hemorrhaging can often also lead to further dangerous cardiac complications.[35] Because people with disabilities are already more susceptible to cardiac complications during pregnancy, preeclampsia and eclampsia are especially dangerous for disabled pregnant people.[36] People with disabilities are also fifty-five percent more likely to experience PPROM during pregnancy.[37] PPROM occurs when the amniotic sac around the fetus ruptures early, increasing the risk of infection and potentially causing sepsis or organ failure.[38] Since pregnant people with disabilities also experience higher risks of infection and sepsis, they are *much* more

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[32] *Id.*
[33] *Preeclampsia,* MAYO CLINIC (Apr. 15, 2022), https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745 (last visited Oct. 22, 2024)..
[34] *See FAQs: Bleeding During Pregnancy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Aug. 2022), https://www.acog.org/womens-health/faqs/bleeding-during-pregnancy (last visited Oct. 22, 2024).
[35] *Facts are Important: Abortion is Healthcare*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare (last visited Mar. 25, 2024).
[36] Gleason, *supra,* at 5.
[37] *Id.*
[38] Aditi Garg & Arpita Jaiswal, *Evaluation and Management of Premature Rupture of Membranes: A Review Article*, CUREUS 15(3), Mar. 24, 2023, at 1, 4.

likely to experience extreme consequences of PPROM such as organ failure.[39]

Data also indicates that people with specific types of disabilities are more likely to experience health- and life-threatening pregnancy complications, making it more likely that people with those disabilities will need abortions as emergency stabilizing care. For example, studies have shown that people with epilepsy may be more likely to experience preeclampsia, PPROM, chorioamnionitis (an infection of the placenta and the amniotic fluid), and a risk of death during pregnancy.[40] Other studies show that people with diabetes may be more likely to face complications including preeclampsia and spontaneous abortion (fetal loss before twenty weeks, also termed miscarriage).[41] People with achondroplasia, the most common type of dwarfism, may face a higher risk of cardiac abnormalities, recurrent respiratory infections, complications involving anesthetics, increased Caesarean delivery rates, and preterm birth.[42]

A recent study that collected anonymized narratives from states with total abortion bans, including Idaho, reported several cases involving life- and health-

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[39] Gleason, *supra,* at 2, 4–7.

[40] *See* Sima I. Patel & Page B. Pennel, *Mgmt. of Epilepsy During Pregnancy: An Update*, 9 THERAPEUTIC ADVANCES IN NEUROLOGICAL DISORDERS 118, 124 (2016).

[41] Am. Diabetes Ass'n., Standards of Care in Diabetes—2023 Abridged for Primary Care Providers, 41 DIABETES J. 4, 28 (2022).

[42] Rauf Melekoglu et al., *Successful Obstetric and Anaesthetic Management of a Pregnant Woman With Achondroplasia,* BMJ CASE REP., Oct. 25, 2017, at 1.

threatening complications for disabled pregnant people. In one, a woman with persistent severe postpartum cardiomyopathy who was at extremely high risk of dying in childbirth had to leave her state for abortion care; in another, a patient with World Health Organization-designated Class III heart failure was referred out of state for care due to her significantly increased risk of maternal mortality or severe morbidity.[43] That study also reported several narratives in which abortion laws limited treatment for underlying medical conditions. In one case, a life-saving liver transplant was cancelled after the patient discovered an unwanted pregnancy. In another, a pregnancy delayed a patient's cancer treatment by seven weeks.[44]

Requiring disabled people to suspend treatment for their underlying health conditions while pregnant also increases the likelihood that they will face dangerous pregnancies that require abortion as emergency treatment. This makes them more susceptible to medical emergencies resulting from their underlying, temporarily untreated medical conditions. Pregnancy therefore can exacerbate other health risks for people with disabilities. For example, Natalizumab is a highly effective and frequently prescribed treatment for relapsing/remitting multiple

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[43] ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, CARE POST-*ROE*: DOCUMENTING CASES OF POOR-QUALITY CARE SINCE THE *DOBBS* DECISION 14 (2024), https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf [hereinafter Care Post-*Roe*].

[44] Care Post-*Roe* 22.

sclerosis ("MS"). Yet, pregnant people with MS are often advised to suspend Natalizumab treatments during pregnancy. A recent study demonstrated that ceasing treatment of Natalizumab directly before or during pregnancy resulted in MS relapses during pregnancy or postpartum. These relapses were potentially life-threatening in one percent of the pregnancies.[45]

For all these reasons, people with disabilities are more likely to have complex pregnancies that are more likely to require emergency stabilizing care, including abortion. To remove EMTALA's protection for such medically necessary care in deference to a state abortion ban would be to place disabled people's health and lives on the line. While Appellants may argue to the contrary, "Idaho cannot credibly maintain that its law *always* permits abortions in cases of PPROM or pre-eclampsia such that its mandate *never* conflicts with federal law." *Moyle*, 144 S.Ct. at 2025 (Jackson, J., dissenting). As discussed below, many pregnant patients in Idaho continue to be denied emergency healthcare for dangerous conditions that disabled people are significantly more likely to experience.

C. Without EMTALA's Protection, Idaho's Abortion Ban Will Continue to Undermine the Medical System in Idaho, Causing Additional Harm to People with Disabilities.

[45] See Kerstin Hellwig et al., *Multiple Sclerosis Disease Activity and Disability Following Discontinuation of Natalizumab for Pregnancy*, J. AM. MED. ASS'N NETWORK OPEN, Jan. 24, 2022, at 11.

If EMTALA's protections are not upheld in the face of an abortion ban that criminalizes necessary stabilizing treatment, Idaho's medical system will be significantly impacted in ways that disproportionately harm disabled people. A 2024 report found that ninety percent of the United States has better maternal pregnancy outcomes than Idaho.[46] A conclusion that EMTALA does not preempt Idaho's abortion ban will lead to further declines in quality of care and an increased physician shortage in Idaho.

Idaho Code § 18-622 creates an uncertain legal landscape, threatens doctors' livelihoods and freedom, and will continue to chill their willingness to provide an abortion even when it is the medically indicated treatment. Though appellants contend that the ban permits all emergency abortions, that contention is disingenuous. Appellants' counsel admitted during oral argument before the Supreme Court that even a doctor who believes in good faith that an abortion is necessary to save a pregnant person's life in an emergency risks being second-guessed and prosecuted under Idaho Code § 18-622 for providing that abortion. *See* Tr. of Oral Arg. *Moyle v. United States,* 144 S. Ct. 2015 (2024) at 25–29. ("And that, Your Honor, is the nature of prosecutorial discretion"). Thus, Idaho doctors are forced to choose between evacuating patients who need emergency

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[46] IDAHO COALITION FOR SAFE HEALTHCARE, A POST ROE IDAHO 5 (available at https://www.idahocsh.org/idaho-physician-wellbeing-action-collaborative) [hereinafter A POST ROE IDAHO].

abortion care from the state or facing prison or loss of a medical license.

In the first four months that the Supreme Court allowed Idaho Code § 18-622 to be enforced, St. Luke's—one of two major hospital systems in the state—had to airlift six pregnant patients out of Idaho; the system only transferred one such patient in the entire preceding year.[47] A doctor with the Idaho Physician Well-Being Action Collaborative reported air evacuations of pregnant patients taking place every week.[48] Data on the outcomes of emergency pregnancy conditions for disabled Idahoans is not available at this time. Still, some disabled patients may be unable to access such airlifts, depending on the nature of the disability and the equipment available to make the transfer. Moreover, interhospital transfer doubles a patient's risk of death and significantly increases risk for adverse outcomes including thromboembolism and sepsis.[49] People with disabilities are significantly more likely to experience these conditions in connection to pregnancy,[50] and may be at higher risk of adverse outcomes during interhospital transfer than nondisabled

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[47] Bracey Harris, *Why Idaho's hospitals are having pregnant patients airlifted out of state,* NBC NEWS (Apr. 25, 2024, 9:54 am) https://www.nbcnews.com/news/us-news/idahos-abortion-emergency-supreme-court-airlifted-rcna148828.
[48] OFFICE OF SENATOR MARIA CANTWELL ET AL., TWO YEARS POST-*DOBBS*: THE NATIONWIDE IMPACTS OF ABORTION BANS 4 (July 11, 2024) https://www.cantwell.senate.gov/imo/media/doc/2024_dobbs_anniversary_national_report_final.pdf [hereinafter Two Years Post-*Dobbs*].
[49] Tina Hernandez-Boussard et al., *Interhospital Facility Transfer in the United States: A Nationwide Outcomes Study,* 13(4) J. PATIENT SAFETY 187 (Dec. 2017).
[50] Gleason, *supra,* at 2, 4–7.

people, likely due to issues with discontinuity of care.[51]

Providers throughout Idaho also report denying and delaying care, including by consulting lawyers and performing extra tests, to ensure compliance with Idaho Code § 18-622. These practices put patients at risk and subject disabled patients to potentially invasive and medically unnecessary procedures that they may not be able to afford. *See, e.g.*, St. Luke's Br. 11–16 ECF 190. Such delays in emergency situations make it more likely that a patient will die, with one study finding that the risk of death from an emergency condition is generally between two and fourteen percent and increases by four percent for every hour that treatment is delayed.[52] While all emergency situations present unique challenges,[53] as described in Section

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[51] Stephanie Mueller et al., *Inter-hospital transfer and patient outcomes: a retrospective cohort study,* 28(11) BMJ QUAL. SAF. 6 (Nov. 2019) (reporting that people with certain existing conditions have a higher risk of mortality after inter-hospital transfer).

[52] Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the Dobbs Ruling,* 328 J. AM. MED. ASS'N 1691, 1691 (2022) (citing Nicholas E. Ingraham et al., *Recent Trends in Admission Diagnosis and Related Mortality in the Medically Critically Ill*, 37 J. INTENSIVE CARE MED. 185, 185 (2022)); see also Jonathan P. Wanderer et al., *Epidemiology of Obstetric-Related ICU Admissions in Maryland: 1999–2008*, 41 CRITICAL CARE MED. 1844 (2013); Christopher W. Seymour et al., *Time to Treatment and Mortality During Mandated Emergency Care for Sepsis,* 376 NEW ENG. J. MED. 2235 (2017); Elyssa Spitzer et al., *Abortion Bans Will Result in More Women Dying*, CTR. FOR AM. PROGRESS (Nov. 2, 2022), https://www.americanprog ress.org/article/abortion-bans-will-result-inmore-women-dying/.

[53] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Aug. 15, 2022), https://www.acog.org/news/ news-articles/2022/08/understanding-medical-

III(A), people with disabilities are more likely to have complex underlying medical conditions, and thus are more likely to suffer as a result of these delays. In other words, Idaho's abortion ban will be especially deadly for disabled people.

Delaying care not only increases a disabled pregnant person's risk of death, but also makes it more likely that the medical care will be unnecessarily emotionally and physically traumatic. Thirty-five-year-old Carmen Broesder of Nampa, Idaho, had been trying to conceive a second child with her boyfriend, but had recurrent pregnancy loss, a reproductive disability.[54] On December 8, 2022, at six weeks pregnant, intense pain and extensive blood loss sent Broesder to the hospital, where she was "heartbroken" when a physician confirmed that her fetus did not have a detectable heartbeat.[55] Rather than provide abortion care to manage Broesder's miscarriage, the hospital sent her home, where she "continued to suffer exponentially," unable to eat from pain and bleeding so heavily that she passed out in her hallway. Over the course of nineteen days, Broesder sought help from four

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emergency-except ions-in-abortion-bans-restrictions (declining to issue a definitive list of conditions that might necessitate abortion care as stabilizing care).

[54] See Paige Skinner, *A Woman Posted Her 19-Day Miscarriage On TikTok Because She Couldn't Access The Care She Needed Due To Abortion Laws*, BUZZFEED (Jan. 4, 2023) https://www.buzzfeednews.com/article/paigeskinner/tiktok-miscarriage-d-c-idaho.

[55] Mary Kekatos, *Idaho woman shares 19-day miscarriage on TikTok, says state's abortion laws prevented her from getting care*, ABC (Jan. 21, 2023), https://abcnews.go.com/Health/idaho-woman-shares-19-day-miscarriage-tiktok-states/story?id=96363578.

medical providers at three different hospitals for the excruciating pain of her ongoing miscarriage. She received just one dose of pain medication. Though she asked for a procedural abortion twice, a doctor refused to provide care because of his "trepidation" about Idaho law.[56] As a result of her sustained, severe blood loss, Broesder was diagnosed with atrial fibrillation, a heart arrhythmia that causes poor blood flow. "I have to deal with these side effects for the rest of my life because of abortion laws," said Broesder.[57]

Under Idaho Code § 18-622 there will continue to be fewer and fewer medical personnel available to provide care to disabled people. Within fifteen months of § 18-622 going into effect, the state lost twenty-two percent of its practicing OB-GYNs, leaving half of Idaho's forty-four counties without access to any practicing obstetricians.[58] Four Idaho maternity units have closed or paused operations since the total abortion ban went into effect due to an inability to recruit staff.[59] One short-staffed hospital admitted that it is routinely directing pregnant

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[56] Nancy Dillon, *Trump Aide Says 'Bleeding Out' Due to Abortion Bans Is Not Real. She Lived It: 'I'm Right Here, Jerk'*, ROLLING STONE (Sept. 13, 2024), https://www.rollingstone.com/politics/politics-news/trump-aide-mcentee-bleeding-out-abortion-1235101263/.
[57] *Id.;* Madison Pauly, *Women on TikTok Are Schooling a Trump Ally Who Denied People Are "Bleeding Out" Due to Abortion Bans*, MOTHER JONES (Sept. 14, 2024), https://www.motherjones.com/politics/2024/09/john-mcentee-trump-tiktok-bleeding-out-abortion-bans-harris-debate/.
[58] Two Years Post-*Dobbs* 16.
[59] *Id.*

patients to other hospitals.[60] The provider exodus and recruiting challenge are not limited to reproductive healthcare: workers across medical specialties report leaving or declining to practice in Idaho due to its abortion bans, adding further stress to a state already unable to meet patient demand, and disproportionately impacting patients with disabilities.[61] Idaho Code § 18-622 is pushing the state medical system to the brink of collapse.[62]

As of 2023, Idaho had the lowest number of active physicians and the lowest number of active surgeons per 100,000 residents in the country.[63] With just one obstetrician per 8,510 Idahoans statewide, thirty percent of Idaho's counties are classified as maternity care deserts, meaning that they do not have any obstetric

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[60] Amanda Seitz, *Dozens of pregnant women, some bleeding or in labor, are turned away from ERs despite federal law*, AP NEWS (Aug. 14, 2024), https://apnews.com/article/pregnant-women-emergency-room-ectopic-er-edd66276d2f6c412c988051b618fb8f9?emci=f18e12d7-e458-ef11-991a-6045bddbfc4b&emdi=b0947d2e-6359-ef11-991a-6045bddbfc4b&ceid=531815.

[61] Angela Palermo, *Idaho needs doctors. But many don't want to come here. What that means for patients*, IDAHO STATESMAN (May 15, 2024), https://www.idahostatesman.com/article285521662.html; TWO YEARS POST-DOBBS 18; A POST ROE IDAHO 3–5; Amanda Sullender, *Idahoans in rural Sandpoint reflect on a year without labor and delivery services,* SPOKESMAN-REVIEW (Mar. 11, 2024), https://www.spokesman.com/stories/2024/mar/11/amid-pro-abortion-protest-idahoans-in-rural-sandpo/?.

[62] Angela Palermo, *Are Idaho's rural hospitals on the brink of collapse? What medical leaders are saying,* IDAHO STATESMAN (May 16, 2024), https://www.idahostatesman.com/news/business/article288478581.html#storylink=cpy.

[63] *U.S. Physician Workforce Data Dashboard: 2023 Key Findings and Definitions*, ASS'N AM. MED. COLL., https://www.aamc.org/data-reports/data/2023-key-findings-and-definitions (last visited Oct. 18, 2024).

providers.[64] Idaho's limited number of reproductive healthcare professionals and rural environment already guarantee long travel times to access OB-GYN care; people living in counties with the highest travel times have to travel up to ninety-three miles and 108 minutes, on average, to reach their nearest birthing hospital.[65] One Idaho doctor reported treating a patient who had traveled hundreds of miles to three different Idaho hospitals seeking emergency abortion care after experiencing PPROM and being denied care by the first two hospitals.[66] By the time the patient was able to receive treatment at the third Idaho hospital, "she was infected, then went on to hemorrhage and require[d] a blood transfusion."[67] The low number of providers and long distances required to reach care are particularly concerning for patients with disabilities for the reasons discussed in Section III(A), *supra*. Public transportation is often unavailable in suburban or rural settings, like much of Idaho.[68]

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[64] March of Dimes, Where You Live Matters: Maternity Care in Idaho 1 (2023); Palermo, *Idaho needs doctors*, *supra*.
[65] Erika Edwards, *Abortion Bans Could Drive Away Young Doctors, New Survey Finds*, NBC NEWS (May 18, 2023), https://www.nbcnews.com/health/health-news/states-abortion-bans-young-doctors-survey-rcna84899.
[66] Emily Corrigan, *My Own Idaho Crisis,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (June 22, 2023), https://www.acog.org/news/news-articles/2023/06/my-own-idaho-crisis.
[67] *Id*.
[68] THE CURRENT STATE 77; *see Overview of Idaho*, IDAHO DEP'T OF HEALTH AND WELFARE, https://www.gethealthy.dhw.idaho.gov/overview-of-idaho (last visited Oct. 18, 2024).

Because people with disabilities are more likely to live in poverty as illustrated by Section III(A), *supra*, they are less likely to be able to afford out-of-state travel to get emergency abortion treatment. An emergency helicopter transfer to a hospital in a state able to provide appropriate abortion care can cost tens of thousands of dollars—an immense financial burden that insurers may decline to cover. One Boise patient who developed PPROM refused to be airlifted out of state in part because of the expense, and some Idaho physicians now recommend that their pregnant patients buy medical evacuation insurance to avoid bankruptcy.[69]

CONCLUSION

Idaho Code § 18-622 has altered the standard of care to the detriment of pregnant patients across the state, delaying care, causing preventable complications, and driving up costs. Many of these consequences will harm all residents, but for the reasons described above, they create and exacerbate particular difficulties for people with disabilities. This frustrates a key congressional aim underlying the passage of EMTALA—that all people, and particularly those with disabilities, have access to necessary stabilizing treatment in emergency situations. Accordingly, *Amici* respectfully urge this Court to affirm the district court's

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[69] Bracey Harris, *Air Ambulance Services Stun Patients With Bills*, NBC NEWS (Apr. 19, 2016, 9:37 am), https://www.nbcnews.com/health/health-care/air-ambulance-services-stun-patients-bills-n558371; Harris, *Why Idaho's hospitals*, *supra*; TWO YEARS POST-*DOBBS* 4.

preliminary injunction.

October 22, 2024 Respectfully Submitted,

/s/

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ADDENDUM: STATEMENT OF INTEREST OF AMICI CURIAE

The Autistic Self Advocacy Network (ASAN) is a national, private, nonprofit organization, run by and for autistic individuals. ASAN provides public education and promotes public policies that benefit autistic individuals and others with developmental or other disabilities. ASAN's advocacy activities include combating stigma, discrimination, and violence against autistic people and others with disabilities; promoting access to healthcare and long-term supports in integrated community settings; and educating the public about the access needs of autistic people. ASAN takes a strong interest in cases that affect the rights of autistic individuals and others with disabilities to participate fully in community life and enjoy the same rights as others without disabilities.

Autistic Women & Nonbinary Network (AWN) provides community support and resources for Autistic women, girls, transfeminine and transmasculine nonbinary people, trans people of all genders, Two Spirit people, and all people of marginalized genders or of no gender. AWN is committed to recognizing and celebrating diversity and the many intersectional experiences in our community. AWN's work includes solidarity aid, community events, publications, fiscal support, and advocacy to empower disabled and autistic people in their fight for disability, gender, and racial justice. We believe in reproductive health, rights, and justice.

The Bazelon Center for Mental Health Law (Bazelon Center) is a nonprofit legal advocacy organization dedicated to advancing the rights of people with disabilities, including people with mental health, developmental, and intellectual disabilities, for over 50 years. The Bazelon Center seeks a society where people with disabilities live with autonomy, dignity, and opportunities, supported by law, policy, and practices that help them reach their full potential.

Disability Law United (DLU) is a national nonprofit organization whose mission is to defend human and civil rights secured by law, focusing on intersectional disability justice. DLU's efforts to defend human and civil rights extend to all walks of life, including ensuring that individuals with disabilities can access all advantages, privileges, benefits, and health programs and activities offered by public and private entities in the United States. People with disabilities face structural barriers as well as conscious and unconscious bias when seeking and receiving healthcare. DLU litigates to tear down those barriers and address those biases to ensure that people with disabilities do not continue to suffer such discrimination.

Disability Rights Advocates (DRA) is based in Berkeley, California, with offices in New York City, New York and Chicago, Illinois. DRA is a national nonprofit public interest legal center recognized for its expertise on issues affecting people with disabilities. DRA is dedicated to ensuring dignity, equality, and

opportunity for people with all types of disabilities, and to securing their civil 3 rights. To accomplish those aims, DRA represents clients with disabilities who face discrimination or other violations of federal or state civil rights or federal constitutional protections in complex, system-changing class action and impact litigation. DRA is generally acknowledged to be one of the leading public interest disability rights litigation organizations in the country, taking on precedent-setting disability rights class actions across the nation.

Disability Rights California is the state and federally designated protection and advocacy system for California, with a mission to advance the legal rights of people with disabilities pursuant to Welf. & Inst. Code § 4900 et seq. Disability Rights California was established in 1978 and is the largest disability rights advocacy group in the nation. In the past fiscal year alone, Disability Rights California assisted more than 20,000 disabled individuals throughout California.

Disability Rights Education and Defense Fund (DREDF) is a national non-profit law and policy organization dedicated to protecting and advancing the civil rights of people with disabilities. Based in Berkeley, California, DREDF has remained board- and staff-led by people with disabilities since its founding in 1979. DREDF pursues its mission through education, advocacy, and law reform efforts, and is nationally recognized for its expertise in the interpretation of California and federal disability civil rights laws. As part of its mission, DREDF

works to ensure that people with disabilities have the legal protections, including effective legal remedies, necessary to vindicate their right to be free from discrimination.

Disability Rights Oregon (DRO) is federally mandated to protect the rights of people with disabilities in our state. *See e.g.*, the Protection and Advocacy for Individuals Rights (PAIR) Act, 29 U.S.C. 794e, et seq., and ORS 192.517 (2023). For over forty years, DRO has worked to transform systems, policies and practices to protect the rights of people with disabilities including filing multiple Emergency Medical Treatment and Active Labor Act (EMTALA) complaints as well as writing a public report regarding hospitals' obligations to provide appropriate medical screening, stabilization, transfer or treatment in Oregon. DRO has the knowledge, experience and interest in the issues raised by the parties regarding ensuring equitable access to EMTALA.

Disability Rights Washington (DRW) is the nonprofit protection and advocacy system designated by the governor of the state of Washington to protect and advocate for the rights of Washington State residents with disabilities. Disability Rights Washington believes people with disabilities have the right to access reproductive care and has engaged in various forms of legal advocacy to protect this right. Disability Rights Washington also advocates for nondiscrimination in the provision of medical care and advocates against patient

dumping, a practice that EMTALA was enacted to prevent.

Legal Voice is a regional non-profit public interest legal organization dedicated to advancing gender justice and liberation across the Pacific Northwest through litigation, legislative advocacy, and community education. Legal Voice has participated as counsel and as amicus curiae in cases throughout the Northwest and the country involving access to abortion and other forms of healthcare, as a matter of reproductive justice and fundamental equality. For the past year, Legal Voice has directed a project in Idaho dedicated to access to reproductive healthcare for people with disabilities.

The National Council on Independent Living (NCIL) is the longest-running national cross-disability, grassroots organization run by and for people with disabilities. NCIL works to advance independent living and the rights of people with disabilities. NCIL's members include individuals with disabilities, Centers for Independent Living, Statewide Independent Living Councils, and other disability rights advocacy organizations.

National Health Law Program (NHeLP) For more than 55 years, NHeLP has engaged in policy and litigation advocacy on behalf of limited-income people, people with disabilities, older adults, and children. NHeLP provides legal representation and conducts research and policy analysis on issues affecting healthcare coverage for these groups. We work to help people overcome barriers to

care, including the lack of accessible, affordable, and timely care. NHeLP has deep experience working with the EMTALA, the ADA, and the ACA. As such, NHeLP is interested in the issues raised by this case.

Women Enabled International (WEI) advances human rights and justice at the intersection of gender and disability to challenge exclusionary, unjust systems and support the leadership and center the voices of women, girls, and gender-diverse people with disabilities globally. It envisions a world where the human rights and inherent dignity of women, girls, and gender-diverse people with disabilities are fully realized and recognized. WEI pioneered the application of an intersectional gender and disability framework to international human rights advocacy and has effectively worked to amplify the voices of women and gender diverse people with disabilities in spaces where their rights are discussed and where decisions affecting their lives are made.

Katherine Pérez, J.D., Ph.D., is a Visiting Professor of Law at Loyola Law School in Los Angeles. Dr. Perez engages in academic research and policy work that prioritizes disabled voices and analyzes how laws reinforce and perpetuate ableism and other interacting systems of oppression. As a disabled woman of color, Dr. Pérez's lived experience informs her advocacy, including in the area of reproductive health.

Robyn Powell, Ph.D., J.D., is a nationally recognized expert in disability

law and policy, with a particular focus on the intersection of disability rights and reproductive justice. Dr. Powell respectfully submits this brief as *amicus curiae* in the above-captioned matter. Dr. Powell is an Assistant Professor at Stetson University College of Law, where she teaches disability law and conducts research on issues affecting people with disabilities. She holds a Doctorate in Social Policy from Brandeis University and a Juris Doctor from Suffolk University Law School. Dr. Powell has extensive experience in disability rights law and policy, having worked as an attorney advisor at the National Council on Disability, an independent federal agency that advises the President and Congress on disability policy. As a disabled woman herself and a scholar in the field, Dr. Powell has a unique perspective on the impact of health exceptions in abortion bans, particularly as they affect disabled individuals. Her research and advocacy work have consistently highlighted the complex intersections of disability, gender, and reproductive rights.

Honorable Tony Coelho is a former California Congressman, original author and sponsor of the Americans with Disabilities Act, and a person with epilepsy. He has had a lifelong interest in advancing disability rights and inclusion. President Bill Clinton appointed him to serve as Chairman of the President's Committee on Employment of People with Disabilities, a position he held from 1994 to 2001. He also served as Vice Chair of the National Task Force on

Employment of Adults with Disabilities and co-chair of the former Census Monitoring Board. He is the past chair of both the Epilepsy Foundation (2005-2007) and the American Association for People with Disabilities (2009-2011) Boards of Directors. In May 2013, he co-authored an article for the American Journal of Public Health titled "Addressing Stigma Through Social Inclusion" with former First Lady Rosalynn Carter and former Surgeon General David Satcher.

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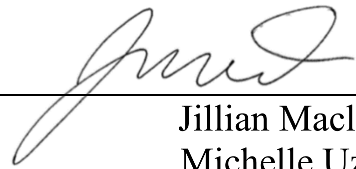
/s/ 

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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