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.

IDAHO,

Petitioner,

v.

UNITED STATES,

Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

AMICUS BRIEF OF THE CHICAGO ABORTION FUND IN SUPPORT OF RESPONDENT

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TABLE OF CONTENTS

Table of Contents

TABLE OF CITED AUTHORITIES

Page

Cases

Statutes

Page

Cited Authorities

Page

Page

Cited Authorities

Page

Rules

I. INTEREST OF *AMICUS CURIAE*

Amicus Curiae the Chicago Abortion Fund ("CAF")[1] is a nonprofit organization that provides financial, logistical, and emotional support to enable people to afford and access abortion services. CAF helps these individuals by fielding helpline requests for support and providing the necessary funding to cover all appointment and related "wrap-around" costs, such as childcare, travel, and lodging. CAF co-founded and helps maintain the Complex Abortion Regional Line for Access ("CARLA") program. CARLA is a patient referral center run in partnership with four Chicago-area academic medical centers offering tertiary abortion care—Rush University Medical Center, University of Illinois Chicago Health, Northwestern Medicine, and University of Chicago Medicine—to aid patients who require complex abortion care at hospitals in Illinois.

In 2020, CAF fielded calls from more than 1,600 people facing barriers to accessing abortion care. In 2021, that number nearly doubled, to approximately 3,000 requests. Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), however, requests have skyrocketed. Since the decision in June 2022, CAF has received more than 18,000 requests for support, with an annual all-time high of more than 12,000 requests in 2023. CAF likewise spent $5.3 million in patient support for appointment and

1. Pursuant to Supreme Court Rule 37.6, counsel for amicus certify that no counsel for any party had any role in authoring this brief in whole or in part, and that no person other than amicus curiae, its members, or its counsel made any monetary contribution intended to fund the preparation or submission of this Brief.

related wrap-around costs. These numbers are indicative of a larger trend: thousands more pregnant people based in states with bans or restrictions on abortion care are now traveling farther for care. These barriers create increased financial and emotional burdens on abortion seekers due to delays in care and more complex travel needs. They also create increased logistical challenges when plans are forced to change—whether due to emergent complex medical needs that require hospital-based care, childcare falling through, a car breaking down, or any combination of unexpected obstacles. In the post-*Dobbs* era, CAF has also experienced a drastic increase in referrals for people traveling from out-of-state who require hospital-based abortion care in Illinois. The aforementioned financial and emotional barriers only increase in intensity and impact when a patient is navigating emergency or complex abortion care.

If the Emergency Medical Treatment & Labor Act ("EMTALA")'s protections disappeared, CAF expects that far more individuals would be forced to travel to Illinois for treatment of pregnancy-related medical emergencies, with some suffering death or serious harm due to delayed emergency care. CAF also expects that it would receive even more requests for support through CARLA, that the average cost to help individuals with appointment and travel needs would rise, and that, absent an increase in funding, CAF could support fewer individuals. CAF has an interest in its grantees' ability to obtain necessary, stabilizing abortion services in their local hospitals. If Idaho prevails, CAF and its grantees will suffer irreparable harm.

II. INTRODUCTION

CAF's work co-founding and maintaining the Complex Abortion Regional Line for Access ("CARLA") offers it a unique perspective on the crucial role that EMTALA can play, and should continue to play, in ensuring that individuals in need of emergency healthcare, including abortions, can obtain such services from their existing providers and medical systems in their home states. This brief contextualizes for the Court the grave risk of harm that Idaho Code § 18-622 poses to individuals in need of emergency abortion services, particularly individuals experiencing financial hardship and people of color. Without the stabilizing care that EMTALA requires hospitals to provide when it is needed—regardless of local restrictions like Idaho Code § 18-622—people with life- and health-threatening pregnancy complications may die or suffer long-term, debilitating health issues.

Idaho's abortion ban contradicts the clear text of federal law. While EMTALA prescribes stabilizing abortion care in life- and health-threatening cases, Idaho Code § 18-622 generally forbids it and contains limited exceptions that are meaningless in practice. This brief shares accounts showing the medical dangers that pregnancy can impose, particularly upon people of color; the burdens faced by low-income patients in restrictive states as they try to access stabilizing abortion care; and the costs on non-profit organizations like CAF to aid individuals who require urgent abortion services and cannot otherwise receive care in their home states.

The testimonials collected for this brief are not sworn testimony or record evidence, but they are a unique source

of insight into the circumstances of patients, providers, and abortion funds as they navigate the landscape of emergency abortion care.

III. ARGUMENT

A. EMTALA requires physicians to provide stabilizing treatment to pregnant patients—including, where necessary, termination of pregnancy.

The plain language of EMTALA provides that a covered hospital violates the statute if an individual "come[s] to [the] hospital" with "an emergency medical condition" and the hospital fails to provide "[n]ecessary stabilizing treatment"—that is, "such further medical examination and such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A). It is well established in the medical literature that, for certain medical emergencies, abortion can be a "[n]ecessary stabilizing treatment."[2] In such cases, EMTALA should ensure that individuals with pregnancy-related emergency medical conditions receive the time-sensitive, critical care needed to prevent death or serious impairment.

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2. *See* Kimberly Chernoby, et al., *Pregnancy Complications After Dobbs: The Role of EMTALA*, 25 W. J. Emergency Med. 79, 79 (2024); Andrea MacDonald, et al., *The Challenge of Emergency Abortion Care Following the Dobbs Ruling*, 328 JAMA 1691, 1691–92 (2022) Sara Rosenbaum, et. al., *Will EMTALA Be There for People with Pregnancy-Related Emergencies?*, 387 N. Engl. J. Med. 863, 865 (2022).

In contrast, Idaho's law bans abortion in virtually all cases. Under Idaho Code § 18-622(1), "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion." *Id.* An abortion occurs when a person uses "any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." Idaho Code § 18-604(1). Two narrow exceptions are provided:

> (i) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and
>
> (ii) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself . . . .

Idaho Code § 18-622(2)(a)(i)-(ii). There is no exception allowing a physician to perform an abortion in cases in which the patient requires an abortion to *stabilize* a pregnancy-related emergency, even if the abortion is not yet *necessary* to prevent the patient's death. Absent such an exception, providers face serious penalties[3] and must grapple with whether to comply with Idaho's law or EMTALA.

B. Failure to provide emergency abortion care when required causes irrevocable, catastrophic harm to patients.

Post-*Dobbs*, navigating state and federal abortion laws has led to fear, uncertainty, and confusion for providers and patients. It has also led to calls for help—hundreds of which have been answered via the CARLA helpline. In partnership with Chicago-area hospitals and partially funded by state government entities, the CARLA program is designed to give appropriate and expeditious treatment to patients who present for abortions at clinics but require a higher level of care than clinics can provide. CARLA's Nurse Navigators, in collaboration with CAF Support Coordinators, are specially trained to aid patients with complex medical needs in scheduling appointments within hospital systems, acquiring required pre-operative testing, and arranging insurance coverage, payment, transportation, and childcare associated with getting needed medical care.

3. A violation of Idaho Code § 18-622(1) is a felony offense punishable by two to five years' of imprisonment and the suspension of a provider's medical license.

For the people working with CARLA, the need for clarity about EMTALA's protections is not an abstract question in a legal brief. Each minute a physician waits for a patient's condition to deteriorate to the point where an abortion is "needed" to save their life, as required by state laws like Idaho Code § 18-622—or each minute spent waiting for review from a hospital's legal department—is a moment the patient is not receiving the stabilizing treatment that federal law guarantees. Emergency treatment, by definition, requires physicians to act quickly. Timing is essential, as a patient's condition can deteriorate rapidly and with little or no warning. Detailing her experience with patients from restrictive states, Dr. Laura Laursen, Co-Director of CARLA, reflected:

> I have seen multiple patients whose amniotic bags have ruptured early (previable preterm rupture of membranes) and they have flown to Chicago for care, while hoping they didn't get an infection or deliver on their way. Other patients have had bleeding early in their pregnancy and placenta adhered to their cesarean section scar (placenta accreta). They were discharged home from emergency departments and left to navigate their care on their own.

Dr. Laursen referred to these patients as "lucky" because CARLA was able to intervene.

As Dr. Laursen's colleague, Dr. Jonah Fleisher, the other Co-Director of CARLA, explained:

> [T]here are numerous medical conditions that are emergencies—and for which CARLA could

> never help quickly enough. Uterine hemorrhage may occur at any point in pregnancy, either from a subchorionic hemorrhage or an impending miscarriage. If this occurs too early in pregnancy for the fetus to survive outside of the uterus, the **only** [medical treatment] is an abortion, and there is no time to transfer the patient to another state for care. While blood transfusion is crucial, this cannot replace emergency abortion care, and massive blood transfusion can itself be life-threatening by creating problems with electrolytes, the body's normal coagulation processes, fluid overload, and heart failure.

These patients are not statistical anomalies. There are thousands more patients across the United States in similar circumstances. They all must attempt to navigate emergency healthcare, and their fate may depend on their ability to travel out-of-state for treatment. Dr. Allison Cowett is the Medical Director of Family Planning Associates Chicago, the largest independent abortion care facility in Illinois. Since this Court's decision in *Dobbs*, her facility has experienced "a one hundred percent increase in the number of people from outside Illinois seeking abortion care, with one in three of [its] patients now traveling from out of state." For many of Dr. Cowett's patients, the decision to get an abortion is a question of survival. Their priority is remaining "alive to care for their children or to preserve their future fertility." Dr. Cowett has encountered many such patients who traveled to her clinic from outside of Illinois. By way of one example, Dr. Cowett described a "woman whose membranes had ruptured several weeks ago with no

chance for the pregnancy to survive and a high risk of infection and sepsis," but who could not receive treatment in her home state. Each of these doctors' patients have faced potentially life-threatening conditions and could have died if they were unable to travel to Illinois for abortion care and receive financial support for that travel.

For all of these patients, Dr. Laursen explains that "travel does not replace emergency care." Studies show that mortality rates increase when patients cannot access local medical care, particularly among patients "with time-sensitive hospitalizations."[4] Other studies show that a delay between the presentment of emergent symptoms and the initiation of treatment "is likely to result in negative consequences and poor outcomes."[5] Dr. Cowett

4. Tarun Ramesh & Emily Gee, *Rural Hospital Closures Reduce Access to Emergency Care*, Am. Progress (Sept. 9, 2019), https://www.americanprogress.org/article/rural-hospital-closures-reduce-access-emergency-care/.

5. Adel Darraj, et al., *The Association between Emergency Department Overcrowding and Delay in Treatment: A Systematic Review*, 11 Healthcare (Basel) 385, 385 (2023). Making matters worse, many restrictive states have enacted legislation attempting to limit a patient's ability to travel outside of the state for care. Such measures increase logistical burdens and delays as well as the dangers of a pregnancy-related emergency. *See* Glenn Cohen, et al., *The New Threat to Medical Travel for Abortion*, Am. J. Med. (Dec. 18, 2023), https://www.amjmed.com/article/S0002-9343(23)00759-3/fulltext. And even when the patient can make it in time to a hospital that provides abortions, the hospital may be so overrun with out-of-state patients seeking abortion care that the patient is *still* forced to wait. *See, e.g.*, Kristen Schorsch, *Abortion Bans Are Fueling a Rise in High-Risk Patients Heading to Illinois Hospitals*, NPR (Aug. 23, 2023), https://www.npr.org/sections/health-shots/2023/08/23/1193898181/abortion-bans-are-fueling-

states that countless patients who cannot afford to travel out-of-state—and even ones who can but lose the battle against a ticking clock—risk "permanent loss of fertility, irreversible organ failure, and even death when chronic medical conditions or unavoidable bleeding and infection go untreated." Dr. Cowett shares: "I know that these lives can and should be saved."

1. Traveling out-of-state for emergency abortion care is not a sustainable solution for patients in crisis.

Idaho's total abortion ban could not come at a worse time. In Idaho, almost thirty percent of counties are defined as maternity care deserts, with close to twenty percent of women with no birthing hospital within thirty minutes of their home.[6] Maternity wards have shut down in Idaho, with many citing the abortion ban as a primary reason.[7] Idaho is not alone: even in restrictive states that have managed to retain a staff of OBGYNs,

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a-rise-in-high-risk-patients-heading-to-illinois-hospi ("Since Roe fell, [Dr. Jonah] Fleisher estimates [his Chicago-based hospital] system is treating at least three times more patients who are traveling from other states for abortion care.").

6. *Where You Live Matters: Maternity Care Access in Idaho*, March of Dimes (2023), https:// www.marchofdimes.org/peristats/reports/idaho/maternity-care-deserts (last visited Mar. 27, 2024).

7. Julianne McShane, *Pregnant with No OB-GYNs Around: In Idaho, Maternity Care Became a Casualty of Its Abortion Ban*, NBC News (Sept. 30, 2023), https://www.nbcnews.com/health/womens-health/pregnant-women-struggle-find-care-idaho-abortion-ban-rcna117872#:~:text=Bonner%20General%20announced%20the%20closing,reproductive%20laws%20in%20the%20country.

fear and uncertainty about the care doctors can provide has left pregnant patients scrambling for emergency care across state lines. For patients not able to finance that trip themselves, costs are increasingly borne by nonprofit abortion funds who have seen skyrocketing demand from patients in crisis and in need of time-sensitive emergency care. This is a drastic situation that will only get worse without the protections offered under EMTALA.

As Megan Jeyifo, Executive Director of CAF, summarized, "[i]n 2018, we supported less than 200 people. Now, we hear from that many people in a week."[8] CAF's Movement Building director, Alicia Hurtado, further explains that while those accessing abortion care in a hospital setting make up just one percent of the support requests CAF receives on the helpline, the support required to get these individuals to the care they need makes up twenty percent of CAF's direct service budget. In fact, Ms. Jeyifo reports that patients seeking hospital-based abortion care face "an average gap of over $3,000 for travel and appointment costs." This is an insurmountable burden for most of CAF's clients, particularly those without health insurance or whose health insurance will not cover out-of-state care—some of the very patients Congress intended for EMTALA to protect.[9]

8. *See also* Kate Chappell, *Abortion Funds See Surge in Demand as Out-of-State Patients Flood Illinois*, NBC 5 (Oct. 18, 2022), https://www.nbcchicago.com/news/local/demand-for-abortion-access-in-illinois-surges-after-supreme-court-overturns-roe-v-wade /297 12 41/? eType=E mailBlast Content&eI d=3340 4475-79 41-4cb9-a7f8-c7fbf0e14c91.

9. *See, e.g.*, *Arrington v. Wong*, 237 F.3d 1066, 1073–74 (9th Cir. 2001) ("[T]he overarching purpose of EMTALA is to ensure

Without access to stabilizing abortion services at an in-state hospital, as required under EMTALA, patients with pregnancy-related life- and health-threatening medical emergencies will be forced to navigate the costly and confusing process of obtaining treatment from an out-of-state provider. CAF already serves patients grappling with urgent abortion needs. Indeed, CAF's Director of Services Meghan Daniel, PhD, notes that "[t]he creation of the CARLA program emerged as a critical response to this [post-*Dobbs*] surge in the need for hospital-based abortion care in Illinois." Many of these clients experience "common, chronic medical conditions, either pre-existing or arising from pregnancy itself, that can make their pregnancies dangerous," Dr. Daniel relays. Their conditions may require prompt abortion care.

For example, CAF Support Coordinator Ariana C.[10] reports that she recently supported a patient from a restrictive state who "urgently needed abortion care and had to travel for hours to a Chicago hospital within a tight two-day window." CAF secured the necessary resources for this patient to receive timely care. Ms. C notes that

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that patients, particularly the indigent and underinsured, receive adequate emergency medical care.") (cleaned up and citations omitted); *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (EMTALA's "core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat."); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136 (8th Cir. 1996) (explaining that EMTALA prevents the "'dumping' of uninsured, underinsured, or indigent patients by hospitals who did not want to treat them. A patient is 'dumped' when he or she is shunted off by one hospital to another.").

10. Ms. C's last name is not included to protect her privacy.

without CAF's urgent attention, patients requiring access to emergency care could face "critical, potentially life-threatening situations." Mx. Hurtado agrees, explaining that "[f]orcing individuals to travel to receive life-saving abortion care would both put the physical and mental health of the people we support in danger and further strain the networks of support in place for people seeking abortion care."

Given the logistical imposition and expense of travel forced on low-income patients facing pregnancy-related emergencies, it is critical that the Court preserve EMTALA's express dictate that hospitals provide stabilizing treatment for *all* patients.

C. Rural and financially burdened pregnant patients are particularly impacted by laws like Idaho Code § 18-622.

EMTALA's protections are paramount for patients with limited resources. When a hospital refuses to treat such a patient who is suffering a medical emergency, the patient may not have the time or money to travel to another facility in time to stabilize the condition. Abortion funds that serve patients living in rural areas in restrictive states ("Restrictive State Funds") can attest to these burdens. Restrictive State Funds report that if Idaho's ban were allowed to take effect, without the protections EMTALA provides, it would harm people from rural communities in two particular ways. First, Idaho's ban would increase the cost and time needed to obtain care, further imperiling patients with limited resources who suffer life- or health-threatening pregnancy emergencies. Second, Idaho's ban would restrict legal abortions even in cases in which the patient's life is at risk.

1. Idaho's ban would increase the cost and time needed for financially burdened people living in rural communities to obtain stabilizing care.

Today, even while EMTALA's requirements for hospitals are in place, Restrictive State Funds act to support patients requiring costly abortion services far from their homes. One such Restrictive State Fund, Texas Equal Access Fund, receives requests from patients in rural areas "who need abortion care but are being forced to travel hundreds of miles to access time-sensitive, critical care that should be readily available in their communities." Another Restrictive State Fund, Nebraska Abortion Resources, assists people in finding care because the state's "vast rural expanses [mean] many communities are over five hours away from the nearest provider of safe and legal abortion services." It is challenging for Restrictive State Funds to service patients in these circumstances, even without the added pressure imposed by a life- or health-threatening emergency.

In non-emergencies, some Restrictive State Fund patients, such as those supported by Fund Texas Choice, travel an average of 1,600 miles roundtrip to access care. Some are forced to wait two or three weeks to obtain an appointment. Surmounting these barriers is difficult for all people, but is simply not feasible for patients with a life- or health-threatening emergency. As Fund Texas Choice notes, "[i]n an emergency situation, clients do not have weeks to wait to get an appointment." The consequences of abortion bans like Idaho's can be severe—if not, deadly.[11]

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11. *See, e.g.*, Stephania Taladrid, *Did an Abortion Ban Cost a Young Texas Woman Her Life?*, New Yorker (Jan. 8, 2024),

That is precisely the harm that EMTALA should prevent. A patient's ability to pay or their present medical condition are not justifications for a hospital to deny stabilizing treatment, especially when the patient may be otherwise unable to obtain the necessary care in time.

2. Idaho's ban will chill legal abortions, even in cases in which the patient's life is at risk.

Idaho argued below that its total abortion ban does not pose a threat to patients' safety or conflict with EMTALA.[12] But even if the Court were to believe that Idaho's narrow exceptions work in practice, allowing surgical treatments for ectopic pregnancies or where otherwise necessary to prevent death,[13] the Act still thwarts EMTALA's purpose by chilling access to these kinds of legal abortions.

For example, Texas Equal Access Fund reports that providers in states with laws like Idaho's are turning

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https://www.newyorker.com/magazine/2024/01/15/abortion-high-risk-pregnancy-yeni-glick; Niha Masih & Maegan Vazquez, *Texas Attorney General Blocks Temporary Lift on Abortion Ban for Complicated Pregnancies*, Wash. Post (Aug. 5, 2023), https://www.washingtonpost.com/politics/2023/08/05/texas-abortion-ban-pregnancy-complications/ (One patient "could not have the procedure even as her fetus had no chance of surviving . . . ; she was only allowed to deliver after she became septic, leaving her with permanent physical damage.").

12. *See generally* Def.-Appellant's Ninth Cir. Br., No. 23-35440, ECF 12-1.

13. *Id.* at 6–7.

patients with ectopic pregnancies "away to find care in another state" because of the "legal risks." Not only is it dangerous to delay treatment of an ectopic pregnancy, but it also poses an unnecessary hardship on the patient. Patients that have contacted the Frontera Fund for help are forced to wait or go on "journey[s] fraught with emotional and financial hardship," just to obtain legal abortion care for life-threatening pregnancy complications. Idaho may contend that abortion care necessary to save the pregnant person's life is still permissible in the state, but the experiences of Restrictive State Funds demonstrate that patients seeking legal medical services are being turned away from hospitals, even when there is no other hospital near their home and when they cannot afford to seek care out-of-state.

The chilling effect felt by financially burdened and rural people has been compounded by providers' desertion of restrictive states.[14] Half of all 254 counties in Texas, for example, have no OBGYNs.[15] Likewise, as explained by one Restrictive State Fund, Northwest Abortion Access Fund, one hospital in Idaho closed its OBGYN

14. John Cullen, *A Worsening Crisis: Obstetric Care in Rural America*, Harv. Med. Sch. Ctr. Primary Care (Mar. 25, 2021), https://info.primarycare.hms.harvard.edu/perspectives/articles/obstetric-care-rural-america ("It's now more dangerous to birth a child than it was 20 years ago, and this is particularly true for women of color and women living in rural communities. There are many reasons for this, but one important component is the development of maternity care deserts.").

15. *Women and Women's Health Providers: Metro v. Non-Metro*, Health Pro. Res. Ctr. (May 2021), www.dshs.texas.gov/sites/default/files/chs/hprc/publications/WomensHealthProviders.pdf (last visited Mar. 27, 2024).

department in response to the state's restrictive abortion laws, while OBGYNs throughout the state are leaving to practice elsewhere. Pregnant patients without access to obstetrics care are more likely to experience negative health outcomes.[16] This is exemplified by a patient who approached a Restrictive State Fund, Frontera Fund, when local hospitals forced her to wait a week to receive care, even though she had miscarried. Worse outcomes are likely to result if a patient requires emergency care.

In life-threatening emergencies, pregnant patients in rural states, including those who contact Nebraska Abortion Resources for aid, may have to drive over five hours to reach a hospital. Upon reaching a hospital, providers may then turn the patient away, even if the hospital could legally treat the patient. As Nebraska Abortion Resources described it:

> Such scenarios are not just logistically burdensome; they pose serious threats to the safety and well-being of those involved. In moments of medical emergency, time is a scarce and precious resource. Delayed access to necessary care due to restrictive laws and the ensuing need for cross-state travel amplifies risks, exacerbating the health emergencies these individuals face.

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16. Julianne McShane, *Pregnant with no OB-GYNs around: In Idaho, maternity care became a casualty of its abortion ban*, NBC News (Sept. 30, 2023), https://www.nbcnews.com/health/womens-health/pregnant-women-struggle-find-care-idaho-abortion-ban-rcna117872.

When a provider is restricted from providing otherwise legally available care, the Restrictive State Funds and companion funds like CAF must step in and fill the void. Northwest Abortion Access Fund noted that EMTALA rightfully instills patients' care in the hands of skilled hospitals and providers where they live, otherwise "the urgency of access [is] up to us as helpline volunteers to ensure [patients] can get the care they need out of state." Congress enacted EMTALA specifically to protect patients against this sort of scramble to find medical care in the face of life-threatening emergencies.

IV. CONCLUSION

EMTALA exists to ensure that patients have access to emergency care, including abortion. Idaho's abortion ban conflicts with EMTALA. When a patient presents with an emergent need for a stabilizing abortion, Idaho's law prevents providers from offering the necessary healthcare. As a result, patients are turned away, even if they cannot afford to travel to another state to obtain the needed care. Patients then look to organizations like CAF and the CARLA program, which must scramble against a ticking clock to secure life-saving care for the patient. As CAF Executive Director Megan Jeyifo aptly describes it:

> Systemically marginalized and low-income communities have less access to preventive care, prenatal care, and safe and healthy environments that could reduce the risk of needing emergency abortion care . . . . Forcing people to cross state lines for urgent, emergency abortion care would not only threaten the health and wellbeing of patients and their families, but

> also reify a system that prices out low-income and marginalized communities from accessing lifesaving care as they face travel-related costs in addition to high appointment costs.

For the reasons set forth above, the Court should rule in favor of the Respondent to ensure that, when needed, all people have access to life- and health-saving abortion care in their home states.

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