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 OF AMERICA,

Respondent.

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writs Of Certiorari To The U.S. Court Of Appeals For The Ninth Circuit

BRIEF OF NATIONAL NETWORK OF ABORTION FUNDS AS AMICUS CURIAE IN SUPPORT OF RESPONDENT

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INTERESTS OF AMICUS CURIAE

Amicus the National Network of Abortion Funds (NNAF) is a national membership organization for abortion funds in the United States.[1]

Abortion funds are community-based organizations that support people to overcome the financial and logistical barriers that prevent them from getting the abortions they need and want. Some funds work with abortion clinics and providers to pay for all or part of the cost of an abortion. Many funds also offer logistical, emotional, and financial support directly to people seeking abortions, such as assistance with and money for transportation, lodging, food costs, childcare, and language interpretation. Funds play a key role in helping people navigate the increasingly complex and constantly shifting abortion landscape in the United States.

NNAF has 100 member funds, which together supported over 81,690 people seeking abortions in fiscal year 2023 (the most recent comprehensive data).[2] The volume of people contacting NNAF's member funds for assistance has grown exponentially over the past several years as the legal landscape around abortion laws and access has grown ever more restrictive and complex.

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[1] This brief was not authored, in whole or in part, by counsel for any party, and no person other than NNAF and its counsel paid for the preparation or submission of this brief.

[2] NNAF's fiscal year ends on June 30.

NNAF is dedicated to ensuring that all people have access to the abortions they want and need, when they want and need them, without stigma or barriers. NNAF submits this brief to contextualize the lower courts' decisions in this case by compiling peer-reviewed research and offering its knowledge about the devastating impact on pregnant people and their families when they cannot get emergency abortions where they live, particularly in light of the significant and often insurmountable barriers to getting such care in another state. NNAF's brief also centers the voices and experiences of people who hold marginalized identities or are from under-resourced communities, who are the most likely to be harmed unless this Court reinstates the district court's preliminary injunction.

SUMMARY OF ARGUMENT

All people should have the power and resources to decide whether, when, and how to create a family. Access to abortion is a critical component of that choice. But the current legal landscape puts abortion out of reach for many pregnant people, especially those who hold marginalized identities or are from under-resourced communities. Since this Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), more than a dozen states are enforcing abortion bans and many others have imposed restrictions making abortions more difficult to access. These bans and restrictions prevent pregnant people

from getting health care when they need it, making it more likely they will have severe medical complications the longer care is delayed. Ultimately, these bans and restrictions cause devastating and lasting harm to pregnant people and their families—particularly when denial or delay of abortions is a matter of life or death.

In an attempt to make their bans more palatable to voters (who overwhelmingly support abortion rights),[3] restrictive states have enacted so-called "emergency" exceptions purporting to preserve the life (and sometimes the health) of the pregnant person. But these exceptions are rhetoric, not reality. They are deliberately vague and confusing, and doctors face the threat of lengthy incarceration, loss of license, and fines if an exception is deemed not to apply. As a result, pregnant people with severe medical complications are being denied or delayed in getting the abortions they need until they are actually dying. Those who survive often suffer permanent harm.

In this landscape, the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. §§ 1395dd et seq., also known as the Patient Anti-Dumping Law, promises the bare minimum protection needed to ensure that no matter where they live, pregnant people in emergency situations get the medical care they need. Without EMTALA's protections, the reality has

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[3] Lydia Saad, *Broader Support for Abortion Rights Continues Post*-Dobbs, Gallup (June 14, 2023), https://news.gallup.com/poll/506759/broader-support-abortion-rights-continues-post-dobbs.aspx (only 13% of Americans believe abortion should be illegal under all circumstances).

been and will continue to be devastating for pregnant people facing medical emergencies in restrictive states. For some, travel to another state may not be feasible or safe. Even if travel is possible, abortion seekers face staggering and often insurmountable financial, logistical, and other structural barriers to obtaining abortions in another state. These include paying for substantial out-of-pocket healthcare costs, navigating an ever more complex abortion landscape with a dwindling number of providers and increasingly concentrated need for care, and arranging and paying for complex and expensive travel arrangements to leave the state, among other challenges.

Abortion funds and other support organizations are working tirelessly to support abortion seekers in overcoming these barriers, including people with emergency medical conditions who reach out for help after being denied abortions. But these organizations do not have enough resources to meet the dramatic increase in need for support since *Dobbs*. Abortion funds should not have to use their limited resources as a stopgap to meet the urgent and substantial needs of pregnant people with emergency conditions when that is exactly what EMTALA is intended to do. This Court should affirm the district court's preliminary injunction prohibiting enforcement of Idaho's abortion ban against medical providers and hospitals that provide life-saving abortions required by EMTALA.

ARGUMENT

A. State Abortion Bans Prevent Pregnant People with Emergency Conditions from Getting the Abortions They Need.

Anti-abortion activists often point to life and health "exceptions" as evidence that a person who needs an emergency abortion will still be able to get it. Indeed, in this case, Idaho argues its ban's purported "exception" allowing abortion when a doctor determines it is "necessary to prevent the death of the pregnant woman" prevents any conflict with EMTALA.[4] But this provision does not even purport to protect a pregnant person's health, as required under EMTALA.[5] And in practice, its deliberately vague language about preventing death—like similar provisions in other abortion bans—does just the opposite.

Emergency exceptions to abortion bans are designed to be difficult or impossible to use.[6] They use non-medical and inconsistent terminology and fail to account for the broad range of conditions that may

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[4] *See* Leg. Br. 28 (quoting Idaho Code § 18-622(2)(a)(i)); Idaho Br. 31 (similar).

[5] 42 U.S.C. § 1395dd(e)(1).

[6] *See* Kate Zernike, *Medical Impact of* Roe *Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, N.Y. Times (Sept. 10, 2022), https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html; Elizabeth Nash, *Focusing on Exceptions Misses the True Harm of Abortion Bans*, Guttmacher Inst. (Dec. 12, 2022), https://www.guttmacher.org/article/2022/12/focusing-exceptions-misses-true-harm-abortion-bans.

threaten a pregnant person's life or health.[7] Coupled with the substantial legal and professional risks to doctors of misinterpreting or misapplying an exception—up to and including life imprisonment, loss of license, monetary penalties, and civil liability, not to mention potential harassment and threats by anti-abortion activists—these exceptions in effect prevent doctors from providing abortions even when a pregnant patient has a serious medical condition that threatens their life or health. In this landscape, patients are forced to wait until their conditions deteriorate to the point where the narrow life or health exceptions unmistakably apply (if ever) before their doctors will provide abortions.[8] This means patients cannot trust their doctors to act in their best interests and provide the care they need, eroding the trust between doctor and patient at the heart of quality health

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[7] *See* Am. C. Obstetricians & Gynecologists, *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

[8] *See* Mabel Felix et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/; *Ethics Talk Series on US Abortion Care After* Dobbs*: Wait. What? Some Clinicians Agree to Watch Their Patients Get Sicker?*, Am. Med. Ass'n J. Ethics (Jan. 24, 2023), https://edhub.ama-assn.org/amajournal-of-ethics/audio-player/18752126; Mary Claire Bartlett, *Physician Mens Rea: Applying* United States v. Ruan *to State Abortion Statutes*, 123 Colum. L. Rev. 1699, 1700–01, 1725–30 (2023).

care.[9] At the very least, delayed care causes serious and often permanent physical and psychological harm to the pregnant person.[10] And in many cases, delay is a matter of life or death.

These risks are not hypothetical. A study in the nine months after Texas's prior abortion ban took effect found that hospital patients with serious pregnancy complications were far more likely to suffer significant negative health outcomes as a result of delayed abortions while doctors waited for the emergence of "complications that qualified as an immediate threat to maternal life" under the applicable statutory exception, as compared to patients with similar pregnancy complications in states without such legal restrictions.[11] Many stories have come to light since *Dobbs* of pregnant people with serious medical complications who were denied abortions until they were sick enough that doctors felt legally safe to terminate their pregnancies.[12] As illustrated by *Zurawski v. Texas*, a case

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[9] *See* Tara Lagu et al., *Abortion Bans and Implications for Physician-Patient Trust*, 17 J. Hosp. Med. 499, 499–500 (2022).

[10] *See* Felix et al., *supra* note 8; J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle with Medical Exceptions on Abortion*, N.Y. Times (July 20, 2022), https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html.

[11] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetricians & Gynecologists 648, 649 (2022).

[12] *See* Maya Yang, *Texas Women Give Harrowing Testimony on Impact of Extreme Abortion Ban*, Guardian (July 20, 2023), https://www.theguardian.com/us-news/2023/jul/20/texas-women-pregnancy-abortion-ban (summarizing plaintiff testimony in *Zurawski v. Texas*).

brought by Texans denied "necessary and potentially life-saving" abortions during their pregnancies, exceptions to abortion bans are often so vaguely or confusingly worded that they result in "pervasive fear and uncertainty throughout the medical community regarding [their] scope" and "put patients' lives and physicians' liberty at grave risk."[13] Doctors report that these exceptions are difficult to follow and apply, and force them to alter significantly the care they provide to pregnant patients with serious complications—including waiting for patients to develop life-threatening infections or hemorrhaging before performing abortions.[14] Some pregnant people experiencing medical emergencies have been forced to leave their home state to obtain urgently-needed care.[15] Others were unable

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[13] Pl.'s Original Pet. for Declaratory J. and Appl. for Permanent Inj. at 1, 3, *Zurawski v. Texas*, No. D-1-GN-23-000968 (Travis Cnty. Dist. Ct., Mar. 6, 2023).

[14] *See* Goodman & Ghorayshi, *supra* note 10; *Ethics Talk Series on US Abortion Care After* Dobbs*: Wait. What? Some Clinicians Agree to Watch Their Patients Get Sicker?*, *supra* note 8; Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After* Dobbs, KFF (June 21, 2023), https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/; *Doctors Refusing Potentially Life-Saving Abortion Treatment Over Legal Fears, Indiana Doctor Says*, ABC News (Aug. 24, 2022), https://abcnews.go.com/US/doctors-refusing-potentially-life-saving-abortion-treatment-legal/story?id=88791452; Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*, N.Y. Times (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html?searchResultPosition=163.

[15] *See* Goodman & Ghorayshi, *supra* note 10; *Doctors Refusing Potentially Life-Saving Abortion Treatment Over Legal Fears, Indiana Doctor Says*, *supra* note 14 (interviewing an abortion care provider who has experienced an "influx of patients" from

to leave their home state and had no choice but to wait as their condition worsened. Either way, the result was delayed treatment at a time when delay not only causes devastating and lasting physical and psychological harm, but also can be the difference between life and death.

B. Structural Barriers Prevent Pregnant People in Restrictive States from Accessing Abortions in States Where Abortion Is Lawful and Increase the Likelihood a Pregnant Person Will Need Emergency Care.

EMTALA applies nationwide, but its protections are particularly important in restrictive states, where clinical access to abortions is effectively unavailable even when refusal or delay could place the pregnant person's life or health in serious jeopardy. Even when out-of-state travel is possible, financial, logistical, informational, and other structural barriers can delay or prevent pregnant people from getting abortions in other states where abortion is lawful, making it more likely medical complications will arise and their condition will deteriorate to the point of needing emergency care. And these same structural barriers make it difficult or impossible for pregnant people experiencing

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neighboring states with abortion bans); Bartlett, *supra* note 8, at 1728 ("In the aftermath of *Dobbs*, anecdotal reports suggest widespread physician hesitancy about the legally permissible time to intervene in these scenarios, and as a result, patients are traveling—sometimes hundreds of miles—to states with more liberal abortion access to receive more immediate care.").

medical emergencies to obtain emergency abortions out-of-state. Despite the tireless efforts of abortion funds and other supporters, many abortion seekers are unable to overcome these barriers. EMTALA provides a critical safety net for these people.

1. Lengthy travel is required due to a shortage of abortion providers in states where abortion is lawful.

Pregnant people who need abortions frequently struggle to find available and accessible providers in states where abortion is legal (often referred to as receiving states). In the year following *Dobbs*, more than 60 providers across the country either stopped providing abortions or closed altogether due to new state bans and other pressures.[16] These closures and reductions in services outpaced the modest increase in the number of clinics and capacity in receiving states.[17] This situation is expected to worsen as more states restrict abortion access.[18]

Abortion providers located near states with bans have seen huge surges in patients. The situation is particularly dire in the South and Southwest, where only

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[16] Allison McCann & Amy Schoenfeld Walker, *One Year, 61 Clinics: How* Dobbs *Changed the Abortion Landscape*, N.Y. Times (June 22, 2023), https://www.nytimes.com/interactive/2023/06/22/us/abortion-clinics-dobbs-roe-wade.html.

[17] *See id.*

[18] *See* Mikaela Smith et al., *How Large Should Patient Surges Be? Modeling Number of Abortions in Destination States Post-*Dobbs 5–7 (Mar. 1, 2024) (unpublished manuscript) (on file with author).

a few states continue to permit abortions. For example, the number of abortions performed in New Mexico—the only state bordering Texas that permits abortion—more than tripled in the year and a half following *Dobbs*.[19] Surveys and anecdotal reports indicate that at various points since *Dobbs*, clinic wait times in receiving states have stretched for two or three weeks and sometimes as long as six or seven weeks.[20] This delay is untenable for people needing emergency abortions. And even when a person's condition has not yet deteriorated to crisis levels, delay increases the likelihood an emergency will develop. A recent study indicates that extreme delays in abortions post-*Dobbs* have contributed to worsened health outcomes such as severe infection, significant bleeding requiring transfusion, and severe-range blood pressure.[21]

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[19] *See* Megan Myscofski, *Abortions in New Mexico More Than Triple Post-*Dobbs, Source NM (Dec. 11, 2023), https://sourcenm.com/2023/12/11/abortions-in-new-mexico-more-than-triple-post-dobbs/.

[20] *See* Laura Kusisto, *Women Encounter Abortion Delays as Clinics Draw Patients from Out of State*, Wall Street J. (Feb. 12, 2023), https://www.wsj.com/articles/women-encounter-abortion-delays-as-clinics-draw-patients-from-out-of-state-f40e318b; Daniel Grossman et al., Advancing New Standards in Reprod. Health (ANSIRH), U.C.S.F., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the* Dobbs *Decision* 12–13, 15 (prelim. findings, May 2023), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf; Laura Ungar, *It's Taking Longer to Get an Abortion in the U.S. Doctors Fear Riskier, More Complex Procedures*, Associated Press (Dec. 9, 2023), https://apnews.com/article/abortion-care-wait-times-us-roe-dobbs-7b0a328bb34b0acb3d37e359a63712fc.

[21] *See* Grossman et al., *supra* note 20, at 4, 7–15.

Closures and reductions in abortion services also mean people who need abortions must travel longer distances. Before *Dobbs*, less than 1% of people in the United States lived more than 200 miles from an abortion provider and the average person was 25 miles from a provider. A year later, 14% of people nationwide lived more than 200 miles from the nearest abortion facility, and the average person was 86 miles from a provider.[22] The increase in travel distance is particularly dramatic in restrictive states. For example, in Texas, the average drive time to the closest abortion facility has increased from 0.7 hours (about 43 miles) to more than 7.3 hours (about 500 miles).[23] In Idaho, the average drive time has more than quadrupled, from 0.8 hours (about 40 miles) to more than 3.6 hours (about 235 miles).[24] And many people have to travel even farther to get to a clinic that can provide the care they need due to factors like higher gestational ages or high-risk pregnancies.[25]

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[22] Selena Simmons-Duffin & Shelly Cheng, *How Many Miles Do You Have to Travel to Get Abortion Care? One Professor Maps It*, Nat'l Pub. Radio (June 21, 2023), https://www.npr.org/sections/health-shots/2023/06/21/1183248911/abortion-access-distance-to-care-travel-miles.

[23] *See* Caitlin Myers et al., *Abortion Access Dashboard*, https://abortionaccessdashboard.org (select "Mar. 2022 to Sept. 2023" tab at bottom of page) (updated Sept. 1, 2023).

[24] *See id.*

[25] *See* Kusisto, *supra* note 20; Sofia Resnick, *After* Dobbs, *Abortion Access Is Harder, Comes Later and with a Higher Risk*, Mo. Indep. (June 21, 2023), https://missouriindependent.com/2023/06/21/after-dobbs-abortion-access-is-harder-comes-later-and-with-a-higher-risk/.

The dramatic increase in travel distance is one of the most significant barriers to abortion access.[26] A national study found that an increase in travel distance of up to 100 miles prevents about one in five abortion seekers from reaching a provider.[27] And even for those who overcome this barrier, drastic increases in travel time impact other aspects of a person's life. Abortion care that once may have been attainable without significant investment of time and resources now often requires patients to take time off work and arrange and pay for childcare, food, and lodging.

The barriers to abortion resulting from scarcity of providers are even more significant for people who hold marginalized identities or are from under-resourced communities. A recent study found that since *Dobbs*, Black, Hispanic,[28] and Indigenous communities experienced larger absolute increases in travel time to abortion facilities, as compared to non-Hispanic white populations.[29] Compounding the impact, these communities are less likely to be able to travel longer distances for abortions. One study found that the

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[26] Caitlin Myers, *Measuring the Burden: The Effect of Travel Distance on Abortions and Births*, Inst. Lab. Econ, IZA Discussion Papers 14556, at 12 (July 2021), https://docs.iza.org/dp14556.pdf.

[27] *Id*.

[28] NNAF uses the term "Hispanic" because that is the terminology used in the research being described.

[29] Benjamin Rader et al., *Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the* Dobbs v Jackson Women's Health *Decision*, 328 JAMA 2041, 2046 (2022).

estimated effect of distance on Hispanic people is more than twice as large as on non-Hispanic white people.[30] Another study found that the effects are "particularly pronounced" for Black people.[31] And as discussed in more detail below, poor and working-class communities are also less likely to overcome the logistical and financial barriers raised by longer travel times.

Long appointment wait times and travel times due to lack of available providers underscore the importance of EMTALA's protections. EMTALA ensures pregnant people in emergency situations who cannot wait for and travel to an out-of-state appointment get the life-saving abortions they need regardless of where they live. This includes people whose conditions become emergencies because they could not overcome these barriers earlier in their pregnancies.

2. Staggering costs and complicated logistics compound abortion seekers' difficulty in accessing care.

Many people who need abortions, including those in the midst of a medical emergency, cannot afford them. This makes EMTALA's promise of emergency

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[30] Scott Cunningham et al., Nat'l Bureau of Econ. Res., Working Paper No. 23366, *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions* 22 (2017), https://www.nber.org/system/files/working_papers/w23366/revisions/w23366.rev1.pdf. *See supra* note 28, regarding use of the term "Hispanic."

[31] Myers, *Measuring the Burden: The Effect of Travel Distance on Abortions and Births*, *supra* note 26, at 3.

care regardless of ability to pay all the more important.[32]

Abortion care is expensive. First trimester abortions typically cost about $570 for a medication abortion and $625 for a procedural abortion, but can be as high as $1,000 or more.[33] Abortions later in pregnancy are exponentially more expensive, ranging from $2,000 to $30,000 or more.[34]

Most pregnant people, whether facing a medical emergency or not, have to pay these healthcare costs out of pocket—even if they have health insurance.[35] One study that surveyed patients at six abortion-providing facilities nationwide found that although only 36% lacked health insurance, at least 69% were

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[32] *See* 42 U.S.C. § 1395dd(h).

[33] Usha Ranji et al., *Key Facts on Abortion in the United States*, KFF (Nov. 21, 2023), https://www.kff.org/womens-health-policy/issue-brief/key-facts-on-abortion-in-the-united-states/#How-much-do-abortions-cost; Laura McCamy, *Over a Year After the Supreme Court Overturned* Roe v. Wade*, the Cost of an Abortion in the US Can Be as Much as $30,000—or as Little as $150*, Bus. Insider (Oct. 21, 2023), https://www.businessinsider.com/personal-finance/high-risk-low-income-patients-abortion-more-expensive-2023-10.

[34] *See id*.

[35] *See*, *e.g.*, Idaho Code § 41-1848(2)–(3) (prohibiting health plans offered through Idaho's healthcare exchange from providing abortion coverage except in limited circumstances), § 41-3924 (managed care plans must exclude coverage for "elective abortions"; exclusion may be waived by endorsement and the payment of a premium, but such coverage is at the provider's option), § 41-3439 (same for individual nongroup or subscriber's policies).

paying out of pocket for abortions.[36] That same study noted that private health insurance paid for only 12% of all U.S. abortions.[37]

The most common reason reported for not using insurance is that abortion is not covered.[38] Eleven states restrict the type of abortion coverage that private health insurance plans can offer, and twenty-six states have laws that bar all plans participating in their state's health insurance exchange from covering abortion.[39] Medicaid is not of much help either. In thirty-two states and the District of Columbia, Medicaid programs do not pay for any abortions, beyond limited exceptions for cases of life endangerment, rape, or incest.[40] Only seventeen states' Medicaid programs

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[36] Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23(3) Women's Health Issues e173, e177 (2013), https://www.guttmacher.org/sites/default/files/article_files/j.whi_.2013.03.001.pdf.

[37] *Id*. at e173.

[38] *See* Ushma D. Upadhyay et al., *Trends in Self-Pay Charges and Insurance Acceptance for Abortion in the United States, 2017–20*, 41 Health Aff. 507, 508 (2022); Tara Siegel Bernard, *Abortion Insurance Coverage Is Now Much More Complicated*, N.Y. Times (July 12, 2022), https://www.nytimes.com/2022/07/12/your-money/health-insurance/abortion-health-insurance-coverage.html.

[39] Upadhyay et al., *Trends in Self-Pay Charges and Insurance Acceptance for Abortion in the United States, 2017–20*, *supra* note 38, at 508; Julie Appleby, *Three Things to Know About Health Insurance Coverage for Abortion*, Nat'l Pub. Radio (July 13, 2022), https://www.npr.org/sections/health-shots/2022/07/13/1111078951/health-insurance-abortion.

[40] *See* Guttmacher Inst., *State Funding of Abortion under Medicaid* (Aug. 31, 2023), https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid; KFF, *State*

fund abortions for people who need them outside of those limited exceptions.[41]

In addition to paying healthcare costs for abortions, people in restrictive states also have to arrange and pay for travel to and lodging in receiving states, as well as food and other necessities.[42] The majority of abortion seekers (60%) have children and so also need to arrange and pay for childcare.[43] With people in restrictive states often living hundreds of miles from the nearest abortion clinic, travel costs can be significant. Depending on the nature of their procedure and state-mandated waiting periods, most people are required to stay near the clinic at least two nights and sometimes four or more nights. Some clinics also require patients to bring an escort to assist as they enter and exit the

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Funding of Abortions Under Medicaid (updated Mar. 5, 2024), https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-3.

[41] *See* Guttmacher Inst., *State Funding of Abortion under Medicaid*, *supra* note 40.

[42] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Persp. on Sexual & Reprod. Health 95, 98–101 (2017), https://onlinelibrary.wiley.com/doi/epdf/10.1363/psrh.12024; Guttmacher Inst., *Barriers to Abortion Care May Have Cumulative Negative Effects* (Apr. 11, 2017), https://www.guttmacher.org/news-release/2017/barriers-abortion-care-may-have-cumulative-negative-effects.

[43] Jessica D'Argenio Waller, *The Majority of Women Who Seek Abortions Are Already Mothers*, Motherly (June 24, 2022), https://www.mother.ly/health-wellness/womens-health/women-seeking-abortion-are-mothers/ (citing 2019 U.S. Centers for Disease Control and Prevention data).

facility, which adds to travel and lodging costs.[44] And most abortion seekers need and want abortions as soon as possible and do not have the luxury of scheduling their abortion when travel and lodging are most affordable.

In the experience of NNAF's member funds, it is not unusual for the total out-of-pocket abortion costs for a patient from a restrictive state to exceed $2,000, and costs escalate from there if the person is further along in their pregnancy, has a disability, or has other health or logistical needs.[45] These costs are unmanageable for most abortion seekers: three-quarters live on low incomes, and nearly half live below the federal poverty level (defined as $31,200 income for a family of four in 2024).[46] One study concluded that in 39 states,

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[44] *See* Nat'l Abortion Fed'n, *Abortion*, https://prochoice.org/patients/pregnancy-options/abortion/ (last visited Mar. 22, 2024).

[45] *See* Allison McCann, *What It Costs to Get an Abortion Now*, N.Y. Times (Sept. 28, 2022), https://www.nytimes.com/interactive/2022/09/28/us/abortion-costs-funds.html; Sophie Mitra et al., *Extra Costs of Living with a Disability: A Review and Agenda for Research*, 10 Disability & Health J. 475, 479 (2017) (having a disability is associated with a 65% increase in out-of-pocket healthcare costs, all else equal).

[46] *See* Hope Sheils, *Overturning* Roe *is a Poverty Issue*, Geo. J. on Poverty L. & Pol'y Blog (Oct. 14, 2022), https://www.law.georgetown.edu/poverty-journal/blog/overturning-roe-is-a-poverty-issue/#_ftn17; Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of* Roe *Is Deepening Existing Divides*, Guttmacher Inst. (Jan. 17, 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides; U.S. Ctrs. for Medicare & Medicaid Servs., *Federal Poverty Level (FPL)*, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ (last visited Mar. 22, 2024).

the healthcare costs alone for a first-trimester abortion would be "financially catastrophic" (i.e., 40% or more of a household's monthly income after basic needs have been met) for households earning their state's median monthly income—meaning that many households considered middle-income would struggle to afford an abortion.[47] Healthcare costs for a second-trimester abortion would be financially catastrophic for these households in all 50 states.[48] Combined with travel and other necessary costs, abortions are out of reach for the majority of abortion seekers in restrictive states.

Taking time away from work, school, or other responsibilities to obtain abortions poses additional challenges.[49] People from poor and working-class backgrounds, Black and Indigenous people, other people of color, and immigrants often have jobs that do not offer paid sick days.[50] As a result, they will lose wages and may endanger their employment if they take time off

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[47] Carmela Zuniga et al., *Abortion as a Catastrophic Health Expenditure in the United States*, 30 Women's Health Issues 416, 418 & fig. 1 (2020), https://pubmed.ncbi.nlm.nih.gov/32798085/.

[48] *Id*.

[49] *See*, *e.g.*, Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4151926/pdf/AJPH.2013.301378.pdf (listing "difficulties getting time off work" among the reasons people delay their abortions).

[50] *See*, *e.g.*, Chantel Boyens et al., Urban Inst., *Access to Paid Leave Is Lowest Among Workers with the Greatest Needs* 2, 6–9 (2022), https://www.urban.org/sites/default/files/2022-07/Access%20to%20Paid%20Leave%20Is%20Lowest%20among%20Workers%20with%20the%20Greatest%20Needs.pdf.

to obtain abortions. For people living paycheck to paycheck, the staggering and unanticipated financial hit can be a tipping point, with lasting and far-reaching impacts.

Further, Black and Indigenous people and other people of color pay a disproportionate amount of their incomes in out-of-pocket abortion costs due to persistent, systemic economic injustice. On average, Black and Hispanic households earn about half as much as white households and own only about 15 to 20% as much net wealth.[51] According to a Federal Reserve report, Black and Hispanic adults are much more likely than white adults to face difficulty paying their monthly bills if faced with an unexpected $400 expense, regardless of income level.[52]

On top of these challenges, one in five households in the United States has medical debt in collections, with a median debt of about $700, and the numbers are even worse in communities of color and in households with at least one disabled member.[53] Critically,

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[51] Aditya Aladangady & Akila Forde, U.S. Fed. Res. Sys., *Wealth Inequality and the Racial Wealth Gap* (2021), https://www.federalreserve.gov/econres/notes/feds-notes/wealth-inequality-and-the-racial-wealth-gap-20211022.html. *See supra* note 28, regarding use of the term "Hispanic."

[52] U.S. Fed. Res. Sys., *Economic Well-Being of U.S. Households in 2021* 36–37 & fig. 21 (2022), https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf. *See supra* note 28, regarding use of the term "Hispanic."

[53] *See* Urban Inst., *Debt in America: An Interactive Map*, https://apps.urban.org/features/debt-interactive-map (select "Medical"

EMTALA prevents hospitals from refusing or delaying emergency treatment based on unpaid medical debt.[54]

The high cost of getting an abortion means that many pregnant people have to delay or forgo care. But if a health crisis occurs, their only option may be the emergency room. EMTALA thus provides a crucial safety net for people who cannot afford abortions.

3. Complex and shifting legal restrictions, inaccurate and misleading sources, and stigma prevent abortion seekers from accessing reliable information about abortion.

People seeking abortions in medical emergencies, when time is of the essence, need timely and reliable information about how and where to obtain the abortions they need. But if the hospital emergency room refuses to help, the lack of understandable, easy-to-find, and accurate information about abortion is yet another barrier. Even before *Dobbs*, one study found "the pursuit of information about abortion following discovery of an unintended pregnancy can present a stymying barrier, as many people are not familiar with abortion information and options until they need one."[55] People

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tab) (updated Oct. 10, 2023); Neil Bennett et al., *19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away*, U.S. Census Bureau (Apr. 7, 2021), https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

[54] *See* 42 U.S.C. § 1395dd(h).

[55] Megan L. Kavanaugh et al., "*It's Not Something You Talk About Really": Information Barriers Encountered by Women Who*

commonly mention "not knowing where to find abortion care" and "not knowing how to get to a provider" as reasons why their abortion was delayed.[56] This barrier is particularly daunting for people with intellectual disabilities who may struggle to access, understand, and act on information.[57]

Post-*Dobbs*, the rapidly changing and confusing legal landscape around abortion laws and access has worsened the information barrier.[58] Abortion seekers report spending weeks trying to figure out where they can go, the cost, and what restrictions might apply to them (e.g., gestational age restrictions, waiting periods, notice or consent requirements).[59] But people who need emergency abortions do not have the luxury of time. And court rulings can further upend access at a

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Travel Long Distances for Abortion Care, 100 Contraception 79, 82 (2019), https://doi.org/10.1016/j.contraception.2019.03.048.

[56] Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, *supra* note 49, at 1689.

[57] *See* Kathryn Shady et al., *Barriers and Facilitators to Healthcare Access in Adults with Intellectual and Developmental Disorders and Communication Difficulties: An Integrative Review*, 11 Rev. J. Autism Dev. Disorders 39, 47 (2024), https://link.springer.com/article/10.1007/s40489-022-00324-8.

[58] Anthony Izaguirre et al., *Shifting Abortion Laws Cause Confusion for Patients, Clinics*, CBS 19 News (July 1, 2022), https://www.cbs19news.com/story/46802647/shifting-abortion-laws-cause-confusion-for-patients-clinics.

[59] Katia Riddle, *Patients Struggle to Navigate Abortion with Changing Laws and Provider Confusion*, Nat'l Pub. Radio (Oct. 25, 2023), https://www.npr.org/2023/10/25/1208577441/patients-struggle-to-navigate-abortion-with-changing-laws-and-provider-confusion.

moment's notice, leaving abortion seekers in limbo.[60] Even abortion providers and abortion funds report difficulty tracking legal changes in the areas they serve—let alone understanding the risks of criminalization and civil liability for themselves and abortion seekers.[61]

Additionally, there is often inaccurate or unreliable information about abortion on the internet, particularly for people who live in restrictive states.[62] And in many communities, stigma around abortion and the threat of criminalization prevent people from asking questions of or getting reliable answers from friends, family, or their healthcare providers.[63] Pregnant people report seeking information about abortion from the healthcare community but encountering staff who are unhelpful or resistant to linking them to abortion resources, or who provide inaccurate or misleading information about abortion.[64] EMTALA cuts through this uncertainty, ensuring that, as in any medical emergency, pregnant people in crisis know they can go to the closest hospital's emergency room to get the care they need, without shame or stigma.

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[60] *See* Izaguirre et al., *supra* note 58.

[61] *See id.*

[62] Kavanaugh et al., *supra* note 55, at 81–82.

[63] *See id*. at 79, 82; *see also* Elizabeth Ling, *Stigma Makes Abortion Criminalization Possible*, The Nation (Oct. 4, 2023), https://www.thenation.com/article/society/stigma-abortion-criminalization/.

[64] Kavanaugh et al., *supra* note 55, at 81–82.

4. Intimate partner violence poses additional barriers to accessing care.

The structural barriers discussed above are intensified for people experiencing intimate partner violence. Overall, one in three women in the United States experiences sexual violence, physical violence, or stalking by an intimate partner (or a combination of these) in their lifetime, with even higher rates among people who hold marginalized identities or are from under-resourced communities.[65] And research has confirmed the link between violence and pregnancy. Intimate partner violence is associated with a higher risk of unintended pregnancy, and the likelihood and severity of intimate partner violence escalates when someone is pregnant.[66] People in an abusive relationship may have an unintended pregnancy due to coercion, sexual violence, or sabotage of contraception, among other reasons.[67]

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[65] Elizabeth Tobin-Tyler, *A Grim New Reality—Intimate Partner Violence After* Dobbs *and* Bruen, 387 New Eng. J. Med. 1247, 1247 (2022), https://www.nejm.org/doi/pdf/10.1056/NEJMp2209696. This study uses the term "women," but NNAF knows that people of all genders need and want abortions.

[66] *See* Jeanne L. Alhusen et al., *Intimate Partner Violence, Reproductive Coercion, and Unintended Pregnancy in Women with Disabilities*, 13 Disability & Health J. 1, 1–2 (2020), https://www.sciencedirect.com/science/article/abs/pii/S193665741930161X; Rebekah E. Gee et al., *Power Over Parity: Intimate Partner Violence and Issues of Fertility Control*, 201 Am. J. Obstetrics & Gynecology 148.e1, 148.e1, e3–6 (2009), https://pubmed.ncbi.nlm.nih.gov/19564020/.

[67] Tobin-Tyler, *supra* note 65, at 1248.

EMTALA's promise that hospitals will provide stabilizing care to people with medical emergencies is critical for people experiencing intimate partner violence. Impacted people may already be experiencing loss of autonomy and social isolation, making trust, safety, and privacy in the doctor-patient relationship vital.[68] But that trust is eroded when a doctor denies or delays emergency care due to an abortion ban. Additionally, research shows that many pregnant people experiencing intimate partner violence do not tell their partners about their pregnancy because they fear their partners will harm them.[69] If hospitals are unable to provide emergency abortions to people experiencing intimate partner violence, this threat of harm—coupled with the loss of autonomy and social isolation they experience—makes it even more daunting and potentially dangerous for them to navigate the structural barriers to obtaining care.

5. The existence of multiple structural barriers to abortion care compounds their effect.

The intersection of the multiple structural barriers to abortion access discussed above amplifies their

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[68] *See* Tracy A. Battaglia et al., *Survivors of Intimate Partner Violence Speak Out. Trust in the Patient-Provider Relationship*, 18 J. Gen. Internal Med. 617, 621–22 (2003), https://www.medscape.com/viewarticle/460644?form=fpf.

[69] Junda Woo et al., *Abortion Disclosure and the Association with Domestic Violence*, 105 Obstetrics & Gynecology 1329, 1331–33 (2005), https://pubmed.ncbi.nlm.nih.gov/15932825/.

effect, especially in restrictive states where people need to travel long distances to get abortions.[70] This compounding effect creates negative consequences that "may be greater than those of individual barriers" alone,[71] increasing the likelihood that pregnant people will face threats to their lives and health due to delayed or unobtainable care.

For example, delays due to financial and logistical barriers make abortions even more difficult to access and exacerbate conditions that may lead to emergencies. Studies demonstrate that the primary reason people delay their abortion is the need to fundraise for and arrange travel.[72] This is true even if abortion seekers get financial support from abortion funds or other resources. And it is particularly true post-*Dobbs*, when abortion funds are facing unprecedented need for support, costs are skyrocketing, and charitable donations have dropped off.

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[70] *See* Jerman et al., *supra* note 42, at 95.

[71] *Id.* at 100.

[72] Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, *supra* note 49, at 1687–93; *see also* Ushma D. Upadhyay et al., *State Abortion Policies and Medicaid Coverage of Abortion Are Associated with Pregnancy Outcomes Among Individuals Seeking Abortion Recruited Using Google Ads: A National Cohort Study*, 274 Soc. Sci. & Med. 1, 9–10 (2021), https://www.sciencedirect.com/science/article/pii/S0277953621000794?via%3Dihub; Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12 PLoS One No. 1, at 11–13 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5266268/pdf/pone.0169969.pdf.

Delaying an abortion increases the cost and complexity of not only the procedure itself, but also the logistics of accessing care in the first place.[73] The cost of out-of-state travel alone often exceeds what a single abortion fund can provide to support an abortion seeker. As a result, abortion funds often need to coordinate with other funds to maximize available resources. Abortion seekers also frequently need to fundraise on their own to make up gaps in funding. All of this takes time—which often results in abortion seekers pushing out their appointment date to later in pregnancy. This delay, in turn, often increases the cost of the abortion and further limits the availability and accessibility of providers.[74]

The compounding effect of these barriers to abortion makes EMTALA's protections even more essential. When people experiencing medical emergencies are unable to access abortions, the emergency room may be their last chance to survive. EMTALA prevents Idaho and other restrictive states from denying this life-saving health care.

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[73] *See* McCann, *supra* note 45.

[74] Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, *supra* note 49, at 1687–93; Jones & Jerman, *supra* note 72, at 12; Upadhyay et al., *State Abortion Policies*, *supra* note 72, at 10.

C. People Who Need an Abortion Due to an Emergency Condition Face Even More Barriers, Leaving Them with Few (If Any) Options and Potential Long-Term Harm.

In addition to the above barriers, people experiencing medical emergencies face even more obstacles to accessing needed care. Once again, EMTALA provides a critical backstop for people living in restrictive states where abortions are out of reach even for those facing threats to their lives and health.

People who need an abortion due to an emergency medical condition have few, if any, safe options. Doctors in Idaho, Texas, and other restrictive states report that the credible threat of criminal prosecution prevents them from providing life-saving and health-preserving abortions. While some doctors in states with shield laws provide telehealth appointments to abortion seekers in restrictive states,[75] telehealth is not intended to address emergencies. And even when the patient can travel safely (which often is not the case), emergency circumstances make abortions even more complicated and expensive.

For example, there often are fewer providers able to provide abortions to pregnant people with more complex needs arising from emergency medical conditions. The patient's treating doctor in a restrictive

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[75] *See* Soc'y of Fam. Plan., *#WeCount Report: April 2022 to September 2023*, at 5, 8 (Feb. 28, 2024), https://societyfp.org/wp-content/uploads/2023/10/WeCountReport_10.16.23.pdf.

state may not be willing or able to provide a referral. And most doctors do not know how or to whom to make those referrals even if they are willing to do so.[76] Further, hospitals in states where abortion is lawful generally do not explain on their websites whether they offer abortions.[77] Even abortion funds and other support organizations with deep knowledge and relationships with providers report that finding a provider can be challenging and sometimes impossible in these emergency situations.

People who manage to get an emergency appointment with an abortion provider often need to travel farther and pay more to get the care they need. Abortions in more complex situations usually cost more, with high-risk patients reporting abortion costs as high as $30,000, not including additional logistical costs.[78] Specialized travel needs due to the person's medical conditions can increase the complexity and cost of travel arrangements.

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[76] Elizabeth M. Anderson et al., *Willing but Unable: Physicians' Referral Knowledge as Barriers to Abortion Care*, 17 Soc. Sci. & Med.—Population Health 1, 4 (2022), https://www.sciencedirect.com/science/article/pii/S2352827321002779.

[77] Ari B. Friedman et al., *Information About Provision of Abortion on U.S. Hospital Websites: A Cross-Sectional Analysis*, 176 Annals Internal Med. No. 10, at 1–2 (2023).

[78] *See*, *e.g.*, McCamy, *supra* note 33; Kate Wells, *Nearly 97% of Abortions in Michigan Aren't Covered by Insurance. That Could Change*, Mich. Pub. (Sept. 15, 2023), https://www.michiganradio.org/health/2023-09-15/nearly-97-of-abortions-in-michigan-arent-covered-by-insurance-that-could-change.

A recent study documents significant and lasting harms where patients with medical complications threatening their lives or health were denied or delayed in receiving abortions.[79] Long-term effects included "loss of fertility and chronic pelvic pain due to infection or surgery, or heart attack and stroke related to uncontrolled hypertension, as well as effects on mental health."[80] Absent EMTALA's protections, the lack of access to emergency abortions in restrictive states will continue to exacerbate these and other harms. And as discussed below, this impacts people with marginalized identities or from under-resourced communities the most, deepening existing inequities.

D. Systemic Inequities Increase Barriers for the Communities EMTALA was Enacted to Protect.

Congress enacted EMTALA to prevent hospitals from "patient dumping," where patients are transferred, solely for financial reasons, from private to public hospitals without consideration for their medical condition. At the time Congress passed EMTALA, studies showed most victims of dumping were poor and uninsured Black and Hispanic people.[81] Thus,

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[79] *See* Grossman et al., *supra* note 20, at 4–18.

[80] *Id.*, at 17.

[81] Mitchell F. Rice & Woodrow Jones, Jr., *The Uninsured and Patient Dumping: Recent Policy Responses in Indigent Care*, 83 J. Nat'l Med. Ass'n 874, 875 (1991), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2571592/pdf/jnma00269-0044.pdf. *See supra* note 28, regarding use of the term "Hispanic."

EMTALA was enacted against a backdrop of discrimination that harmed some communities much more than others.

Today, the actions of Idaho and other restrictive states result in the same types of disparate impacts EMTALA was intended to prevent. While abortion bans and restrictions harm everyone who is or may become pregnant, they cause even greater harm to people in communities subject to systemic racism and economic injustice. Pervasive inequities across the spectrum of reproductive health care magnify existing barriers to abortion.

To start, racial and income disparities in access to high-quality health care, insurance coverage, and contraception systematically deny people who hold marginalized identities or are from under-resourced communities the autonomy to make decisions about whether and when to become pregnant and make it more likely they will suffer complications when they do.[82] People who lack health insurance before they become pregnant often are unaware of risk factors that contribute to poor pregnancy outcomes, such as hypertension or anemia.[83] Having insurance makes it much

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[82] Fuentes, *supra* note 46; *see also* De-Chih Lee et al., *The Convergence of Racial and Income Disparities in Health Insurance Coverage in the United States*, 20 Int'l J. Equity Health No. 96, 1–2 (2021), https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01436-z.

[83] *See* Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Closing the Coverage Gap Would Improve Black Maternal Health*

more likely that these risk factors get screened and treated before or between pregnancies.

Racial disparities also manifest in higher rates of pregnancy complications, including death.[84] The United States has the highest rate among developed countries of people dying of pregnancy-related complications, with about 700 to 900 deaths each year—most of which are preventable.[85] Black pregnant people are about three times more likely to die than white people, and Indigenous people are twice as likely.[86] Black and Latina pregnant people also are more likely to develop serious pregnancy complications.[87] And they are more likely to experience discrimination and disrespect that contribute to these negative outcomes.[88] There is a "consensus" among researchers and healthcare providers that disproportionately high rates of maternal death and pregnancy complications among Black people, regardless of income and education, are "due to

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6–8 (2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

[84] Fuentes, *supra* note 46.

[85] Solomon, *supra* note 83, at 4.

[86] *Id*.

[87] *Id.* NNAF uses the term "Latina" because that is the terminology used in the research being described. NNAF knows that people of all genders need and want abortions.

[88] Akilah Johnson, *For Some Black Women, the Fear of Death Shadows the Joy of Birth*, Wash. Post (Dec. 14, 2023), https://www.washingtonpost.com/health/interactive/2023/black-women-pregnancy-mortality-fear/; Yousra A. Mohamoud et al., Ctrs. for Disease Control & Prevention, *Vital Signs: Maternity Care Experiences—United States, April 2023*, 72 Morbidity & Mortality Wkly. Rep. 961, 961–67 (2023).

structural racism in the delivery of healthcare services along with their lived experiences of racism, which leads to toxic stress and elevated risk of conditions such as hypertension."[89]

These same disparities also result in stark differences in the ability to access abortion. Studies confirm that Black and Indigenous people, other people of color, low-income people, transgender and nonbinary people, disabled people, immigrants, and young people "are all particularly likely to encounter compounding obstacles to abortion access and be harmed as a result."[90] In a recent study about the impact of abortion restrictions since *Dobbs*, about half of the patients who physicians reported as receiving "poor-quality care due to new restrictions on abortion care" were Black or Latina/Latinx/Hispanic people or other people of color.[91]

These gross inequities in access to health care and outcomes for pregnant people provide essential context as this Court considers whether to require restrictive states like Idaho to provide life-saving and health-preserving abortions to people experiencing medical emergencies. To deny such care would cause devastating and permanent harm, particularly to people who already bear the brunt of systemic racism and

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[89] Solomon, *supra* note 83, at 5.

[90] Fuentes, *supra* note 46.

[91] Grossman et al., *supra* note 20, at 4–5, 17. NNAF uses the term "Latina/Latinx/Hispanic" because that is the terminology used in the study being described.

economic injustice—the same communities Congress intended EMTALA to protect.

E. Despite Extraordinary Efforts, the Need for Support to Access Abortion Far Exceeds Available Resources.

NNAF's network of 100 independent member funds work tirelessly to support as many pregnant people in their communities as possible. But the current need for financial and other support far exceeds their capacity.[92] In the year after *Dobbs*, abortion funds reported a 39% increase in requests for support to access abortions. Funds collectively disbursed almost $37 million to 102,855 abortion seekers, growing funding budgets by 88%. Of that, more than $10 million went to practical support (logistical needs beyond the abortion itself, such as transportation, lodging, childcare, and more)—a 178% increase from the year before.[93]

Immediately following *Dobbs*, funds across the network reported a large increase in donations and then a precipitous drop-off, while the need for support

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[92] Eden Stiffman, *Abortion Funds Face Slowdown in Giving a Year After Supreme Court Ruling*, Chron. Philanthropy (June 12, 2023), https://www.philanthropy.com/article/abortion-funds-face-slowdown-in-giving-a-year-after-supreme-court-ruling; McCann, *supra* note 45.

[93] Press Release, Nat'l Network of Abortion Funds, *Critical Role of Abortion Funds Post-*Roe (Jan. 18, 2024), https://abortionfunds.org/abortion-funds-post-roe/.

only increased.[94] Some funds are routinely forced to stop taking new requests when they exceed their monthly budget.[95] Until now, EMTALA has provided a critical backstop to ensure a minimum level of emergency care for patients with serious medical complications. In seeking to prevent doctors from providing emergency abortions, Idaho and other restrictive states are essentially abandoning pregnant patients and forcing them to seek emergency support from under-resourced and overwhelmed out-of-state healthcare providers, abortion funds, and other support organizations. That outcome is contrary to the letter and spirit of EMTALA.

CONCLUSION

The preliminary injunction ensures that, consistent with EMTALA, a pregnant person who needs an emergency abortion will still be able to get it, no matter where they live. In its absence, this essential health care will be delayed or denied. Many patients in restrictive states—and disproportionately people

[94] Olivia Goldhill, *Abortion Funds Run Short of Money as Demand Soars and Donations Fall*, Stat News (Jan. 23, 2024), https://www.statnews.com/2024/01/23/abortion-fund-warning-demand-up-donations-down/.

[95] Carter Sherman, *'Feels Horrible to Say No': Abortion Funds Run Out of Money as US Demand Surges*, Guardian (Sept. 22, 2023), https://www.theguardian.com/world/2023/sep/22/us-abortion-funds-run-out-of-money-demand-surges.

who hold marginalized identities or are from under-resourced communities—will face insurmountable barriers to obtaining abortions in states where abortions are lawful. Instead, they will be forced to risk their lives and health, with lasting physical, mental, emotional, and financial harm to them and their families. The district court's preliminary injunction should be affirmed.

RESPECTFULLY SUBMITTED this 27th day of March, 2024.

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