Nos. 23-726 & 23-727

IN THE

Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, *et al.*,

Petitioners,

v.

UNITED STATES,

Respondent.

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES,

Respondent.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF DISABILITY RIGHTS ADVOCATES AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

INTERESTS OF *AMICI CURIAE*[1]

Amici are sixteen organizations, scholars, and others that have an interest in preserving and advancing the right of people with disabilities[2] to participate fully and equally in society. *Amici* pursue these goals using various tools, including legal advocacy, training, education, legislation, and public policy development. Many of the *amici* organizations are composed of people with disabilities. A list of *amici* appears in the Appendix below.

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. People with disabilities are just as likely to become pregnant as non-disabled people but face significantly higher risks for severe pregnancy- and birth-related complications, with serious consequences for their health. Additionally, people with disabilities experience significant disparities in access to health care, making access to emergency treatment critical.

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[1] Pursuant to Supreme Court Rule 37.6, *amici* certify that no counsel for any party authored this brief in whole or in part, and that no party or counsel other than the *amici curiae* and their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

[2] Opinions within the disability community vary about whether person-first ("person with a disability") or identity-first ("disabled person") language should be used when writing about disability. *See generally* Erin E. Andrews, Robyn M. Powell, & Kara Ayers, *The Evolution of Disability Language: Choosing Terms to Describe Disability*, 15 DISABILITY & HEALTH J. 1 (2022) (exploring the evolving language preferences among people with disabilities). In this brief, both are used interchangeably.

The precedent set in this case will extend to states across the country with near-total abortion restrictions similar to those in Idaho's statute, potentially affecting millions of disabled people who are or will become pregnant. *Amici* are concerned that if such state restrictions are permitted to negate the protections Congress provided in the Emergency Medical Treatment and Labor Act ("EMTALA"), people with disabilities will suffer serious bodily harm or even death. A conclusion that EMTALA preempts state statutes that ban abortion care, in instances where such care constitutes the necessary stabilizing treatment required by EMTALA, is essential to protecting the lives and health of pregnant people with disabilities.

INTRODUCTION AND SUMMARY OF ARGUMENT

The federal EMTALA statute ensures that Americans most at risk of being denied medical care, including people with disabilities, receive stabilizing treatment during medical emergencies. Idaho Code § 18-622 and similar abortion bans deny at-risk people the medical care necessary to stabilize them and prevent serious harm. Thus, EMTALA preempts such state statutes to the extent they prohibit an abortion necessary to protect a pregnant person's health in an emergency.

Multiple barriers to accessing effective primary and prenatal care place disabled people at risk of being denied access to medical care. These barriers include a lack of accessible transportation to health care providers, inaccessible medical facilities, a lack of adaptive medical equipment, provider bias, and doctors who are not trained to work with or accommodate disabled people. People with disabilities are also more likely to live in poverty, meaning they may lack the time

and resources to procure effective primary and prenatal care, increasing their risk of complex pregnancies.

People with disabilities are also more likely to have medically complex pregnancies, because they often have conditions that interact with their pregnancies in potentially dangerous ways. As a result of these barriers to medical care generally and increased risk factors, pregnant people with disabilities are more likely than non-disabled pregnant people to require abortion care as stabilizing emergency medical treatment protected by EMTALA.

Idaho Code § 18-622 imposes extreme limitations on medical professionals' ability to perform medically necessary abortions. The law is so restrictive that the Idaho Supreme Court called it a "total abortion ban." *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1147 (Idaho 2023). Unless this Court holds that EMTALA preempts the Idaho statute and similar state statutes to the extent they criminalize stabilizing abortion care, these state statutes will defeat EMTALA's protections. The result will be to prevent EMTALA from accomplishing Congress's goal of ensuring that people who face barriers to medical treatment, including disabled pregnant people, receive emergency abortion care when they need it.

A ruling that Idaho Code § 18-622 and similar state statutes are not preempted by EMTALA will also increase barriers to emergency care for at-risk patients. Idaho provides a prime example of the potential consequences of a ruling that the abortion bans are not preempted. Since the implementation of Idaho Code § 18-622, doctors who are no longer able to practice what they view as ethical medicine are leaving the state, and Idaho hospitals are finding it difficult to recruit new doctors. The number of OB-GYNs and

hospitals offering emergency medical care to pregnant people in Idaho has already declined sharply. This decline harms all pregnant people in Idaho, but pregnant people with disabilities are particularly affected by increased travel barriers to accessing emergency medical care, especially emergency abortion care. Many pregnant people with disabilities lack the resources to overcome these barriers.

Amici urge this Court to preserve EMTALA's promise to protect those most at risk of being denied necessary stabilizing treatment during emergency situations. This Court should hold that EMTALA preempts Idaho Code § 18-622 and similar abortion bans in emergency situations where abortions are necessary stabilizing treatment. Without such a holding, people with disabilities, whom EMTALA is meant to protect, will be denied the emergency care they need to protect their lives, health, and wellbeing.

ARGUMENT

I. Congress enacted EMTALA to ensure that at-risk people—including people with disabilities—receive stabilizing medical treatment in emergency situations.

This case centers on whether state laws that criminalize abortions are preempted by EMTALA's guarantee of stabilizing medical treatment in emergency situations. EMTALA requires that all hospitals receiving Medicare funding provide emergency medical care for all people, regardless of wealth, insurance status, or other classifications. EMTALA states, "[i]f any individual . . . has an emergency medical condition, the hospital must provide . . . such treatment as may be required to stabilize the medical condition," or make an appropriate transfer to a facility that can provide such stabilizing

care. 42 U.S.C. § 1395dd(b)(1). When Congress passed this law, it sought to enshrine protections for emergency care for those most in need of medical care, and least likely to be able to access medical care.

People with disabilities fall squarely into this camp, as a group that faces significant obstacles to accessing medical care despite having a greater need for care. Recognizing this, Congress intended the passage of EMTALA to ease access to emergency medical care for disabled people. Indeed, EMTALA is not the only expression of Congress's intent in this area; the law fits within a series of federal statutes reflecting a congressional desire to protect the rights of disabled people in the healthcare context. State laws that threaten access to emergency medical care for people with disabilities—including Idaho Code § 18-622 and similar statutes—frustrate Congress's intent in enacting these federal protections.

A. In enacting EMTALA, Congress was concerned with protecting 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's purpose in passing the law was to broadly guarantee the "provision of adequate emergency room medical services to individuals who seek care." H. Rep. No. 99-241, at 5 (Sept. 11, 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 understood that guaranteeing access to emergency medical care would be necessary to "address the serious problems of this Nation's most vulnerable citizens." 131 Cong. Rec. 28,570 (1985) (statement of Sen. Heinz). Congress thus 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).

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 and protection against patient dumping. 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).

EMTALA requires hospitals "to provide emergency services to individuals with life-threatening or potentially crippling conditions." 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. U. S. Dep't of Health and Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019) (citing 151 Cong. Rec. H177 (2005) (statement of Rep. Weldon)). As discussed below, people with disabilities experience higher risks and worse health outcomes during their pregnancies than non-disabled pregnant people, making

their access to stabilizing care under EMTALA all the more essential.

B. The understanding that EMTALA encompasses effective protection for people with disabilities fits within the broader history of Congress's efforts to ensure access to health care for this at-risk group.

Congress has repeatedly sought to protect access to health care 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 health care programs. 29 U.S.C. § 794. Building on the protections established by Section 504, 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. 42 U.S.C. § 12101(a)(3). The ADA contains multiple provisions that seek to expand access to health care for disabled people. Title II of the statute prohibits discrimination against people with disabilities by public entities, including state and local public health programs, services, and activities, irrespective of receipt of federal funding. 42 U.S.C. § 12132. Title III of the ADA prohibits discrimination on the basis of disability by public accommodations, including by the "professional office of a health care provider, hospital, or other service establishment." 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's efforts to ensure equitable medical treatment for people with disabilities. The efforts of

the disability community on behalf of this legislation are evident in the final law. The ACA—which may "be understood as a disability rights law"—introduced a bevy of protections that expanded access to health care for people with disabilities. Jessica L. Roberts, *Health Law As Disability Rights Law*, 97 MINN. L. REV. 1963, 2021 (2013).

Perhaps most significantly, the ACA specifically prohibits discrimination on the basis of disability for health programs and activities receiving federal financial assistance. 42 U.S.C. § 18116(a). The ACA further protects people with disabilities from the denial of health insurance coverage based on their medical history or pre-existing medical conditions. 42 U.S.C. § 300gg–3; 45 C.F.R. §§ 147.104, 147.106, 147.108. During the debates on the legislation, Senator Sherrod Brown emphasized that the law would ensure "that insurance companies can't drop people for preexisting conditions . . . [and] can't discriminate based on geography or disability." 155 Cong. Rec. 24,437 (2009) (statement of Sen. Brown). Prior to the ACA's passage, people with disabilities were often charged premiums that were higher than those charged to non-disabled people—or they were excluded from coverage entirely.[3] The ACA also significantly expanded coverage under Medicaid, a key source of public financial support for people with disabilities. 42 U.S.C. § 1396d(y)(1). Congress announced its intention to expand the rights of disabled people through the ACA, emphasizing the importance of "ensuring that patients would never be denied treatment based on . . . disability status" as well as the prohibition on excluding people from coverage based on "medical condition (including both

[3] *See* NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 46 (2009).

physical and mental illnesses) . . . and disability." S. Rep. No. 111-89, at 6, 26 (2009).

EMTALA represents one piece of this broader body of legislation designed to ensure access to medical care for people with disabilities. In considering this case, this Court should take account of the serious harm to disabled people that will result if state statutes containing near-total abortion bans are permitted to negate the access to emergency care Congress provided through EMTALA. These consequences are described below.

II. Permitting enforcement of state abortion bans that negate EMTALA's protections will result in serious harm to people with disabilities in Idaho and states with similar bans.

The briefs filed by the United States and other *amici* explain at length why EMTALA preempts state statutes that prohibit abortions necessary to stabilize the health of pregnant people in emergency situations due to a direct conflict with the requirements of EMTALA. In short, except in the extremely narrow circumstances where the state statute permits abortions, it is impossible to comply with both the state statute and federal law when abortion care is the necessary stabilizing treatment required by EMTALA. Idaho Code § 18-622 permits stabilizing abortion care only when it is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a)(i). EMTALA, however, requires a hospital to provide stabilizing treatment in situations beyond those in which a pregnant person risks death. The federal statute 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. § 1395dd(e)(1)(A). EMTALA further requires hospitals to provide care "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). As the United States and other *amici* explain, performance of an abortion is sometimes necessary to stabilize a patient as required by EMTALA. Brief of Respondent at 6–8, 14–20; Brief of St. Luke's in Support of Respondent at 6–12; Brief of the American Hospital Association, the Association of American Medical Colleges, and America's Essential Hospitals at 20–23.

These other briefs also explain why such state statutes "stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Oneok, Inc. v. Learjet, Inc.*, 575 U.S. 373, 377 (2015) (citations and internal quotation marks omitted). As discussed in Section I, *supra*, in enacting EMTALA, Congress sought to protect disabled people by ensuring that hospitals provide stabilizing treatment for all people in emergency medical situations. Yet, Idaho Code § 18-622 and similar abortion bans subject providers to criminal penalties and loss of licensure for providing that essential, health-preserving treatment. These penalties create a plain obstacle to the congressional purpose behind EMTALA.

This brief focuses on pregnant people with disabilities, who 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. Allowing state statutes to strip away EMTALA's protections for emergency stabilizing abortions will increase the 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's 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, making it especially likely that they will need the emergency treatment that EMTALA protects.

Wide-ranging systemic barriers obstruct disabled people's access to medical care, ultimately leading to their increased need for EMTALA's protections. In many cases, transportation is unavailable or inaccessible, medical facilities are inaccessible and lack adaptive equipment, and providers display implicit biases and lack training on how to treat and accommodate disabled people. Many people with disabilities also face financial barriers to accessing care, as they are more likely to have limited resources and to delay care due to the expense. These barriers make it more likely that people with disabilities will not receive preventative and prenatal care and therefore require emergency treatment and the protections Congress provided through EMTALA.

One study found that fifty percent of women with disabilities have experienced logistical barriers to

accessing reproductive health care.[4] One of the most significant of those barriers is transportation.[5] Section II.C, *infra*, describes the logistical barriers to care faced by disabled people in more detail, explaining that these barriers can lead people with disabilities to delay seeking care until emergencies strike.

Even when a disabled person can get transportation to medical care, many health care 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, discriminatory barriers remain.[6] For example, a survey of 256 practices found that forty-four percent of gynecology practices would be unable to accommodate patients with mobility disabilities, making it the most

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[4] M. Antonia Biggs 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.

[5] *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.

[6] *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); 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).

inaccessible subspeciality.[7] A 2017 survey of wheelchair users found 73.8% had experienced physical barriers to accessing primary care in the previous year, resulting in most participants remaining in their wheelchairs, fully clothed, for examination, thereby minimizing doctors' ability to perform medical screenings.[8]

Further, even if a doctor's office is physically accessible, doctors often lack the adaptive equipment like adjustable height exam tables and accessible scales to perform basic screening tests. Some physicians have even reported sending wheelchair users to a zoo, cattle processing plant, supermarket, or grain elevator in order to record their weights because the physicians' practices did not have an accessible weight scale.[9] This problem is pervasive enough that the U.S. Architectural and Transportation Barriers Compliance Board introduced nonmandatory standards for accessible medical equipment in 2017.[10] But while the Department of Justice recently issued a notice of proposed rulemaking to require accessible medical diagnostic equipment for some ADA-regulated entities, it has yet to propose a rule that applies to all ADA-regulated entities, and the rule it has proposed is

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[7] Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment*, 158 ANNALS OF AM. MED. 441, 441 (2013).

[8] Michael D. Stillman et al., *Healthcare Utilization and Associated Barriers Experienced by Wheelchair Users: A Pilot Study*, 10 DISABILITY & HEALTH J. 502, 508 (2017).

[9] 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).

[10] U.S. Architectural & Transp. Barriers Compliance Bd., Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810 (Jan. 9, 2017).

not yet in force.[11] The current lack of accessible medical diagnostic 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.[12]

Beyond physical barriers, many doctors are not trained to work with people with disabilities. Fewer than half of physicians in one survey of over 700 said they were confident they could provide similar quality of care to patients with disabilities as they could to those without disabilities. Over thirty-five percent reported that a lack of formal training on interacting with disabled people was a barrier to their providing effective care.[13] Studies suggest that as a result of insufficient training and biased attitudes toward disabled people, providers make clinical decisions to avoid treating people with disabilities, further curtailing their access to care.[14]

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[11] U.S. Dep't of Just., Nondiscrimination on the Basis of Disability; Accessibility of Medical Diagnostic Equipment of State and Local Government Entities, 89 Fed. Reg. 2183, 2183–84 (Jan. 12, 2024).

[12] 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).

[13] 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).

[14] Tara Lagu et al., *'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities,* 41 HEALTH AFFAIRS 1387, 1391–92 (2022).

Those patients who can obtain care still face discrimination and bias from health care providers. In one survey, eighty-three percent of health care providers had biased attitudes toward disabled people.[15] Many doctors report having discriminatory views of disabled people, seeing them as "entitled" or prone to exaggeration.[16] Some reproductive health providers arbitrarily tell disabled women that pregnancy would be too dangerous for them, which is likely to discourage disabled people from trusting medical advice once they become pregnant.[17] People with disabilities may already be less likely to trust doctors,[18] in part due to the medical system's lengthy history of nonconsensual experimentation on, abuse of, and tendency to favor sterilization of disabled people—a tendency that has unfortunately also appeared in the courts.[19] *See Buck v. Bell*, 274 U.S.

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[15] Laura VanPuymbrouck, *Explicit and Implicit Disability Attitudes of Healthcare Providers*, 65 REHABILITATION PSYCH. 101, 105 (2022).

[16] Tara Lagu et al., *'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities,* 41 HEALTH AFFAIRS 1381, 1391–92 (2022).

[17] *See, e.g.*, NAT'L COUNCIL ON DISABILITY, ROCKING THE CRADLE: ENSURING THE RIGHTS OF PARENTS WITH DISABILITIES AND THEIR CHILDREN 204–06 (2012).

[18] *A Million Conversations: How We're Bridging the Healthcare 'Trust Gap' with Marginalized Communities*, SANOFI (Apr. 3, 2022), https://www.sanofi.com/en/magazine/social- impact/global-poll.

[19] *See generally* PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND *BUCK V. BELL* (2008); Robin M. Powell & Michael A. Stein, *Persons with Disabilities and Their Sexual, Reproductive, and Parenting Rights: An International and Comparative Analysis*, 11 FRONT. L. CHINA 53, 60–68 (2016); NAT'L P'SHIP FOR WOMEN & FAMILIES AND AUTISTIC SELF ADVOC. NETWORK, ACCESS, AUTONOMY AND DIGNITY: ABORTION CARE FOR PEOPLE WITH DISABILITIES 4–5 (2021), https://nati

200, 207 (1927) (holding that involuntary sterilization of an intellectually disabled woman was not unconstitutional, because "[t]hree generations of imbeciles are enough."). Patients who experience discrimination, whether from providers' attitudes or being sent to a grain elevator to be weighed, are more likely to underutilize and delay medical care, including prenatal care.[20]

Proper prenatal care allows early diagnosis and treatment of pregnancy complications,[21] but pregnant people with disabilities are less likely to receive timely and consistent prenatal care. For example, one study found that women with intellectual disabilities are less likely to receive prenatal care in the first trimester compared to their non-disabled counterparts.[22] Additionally, certain disability-related chronic conditions are linked to irregular menstrual periods, making

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onalpartnership.org/wp-content/uploads/2023/02/repro-disability-abortion.pdf.

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

[21] *See, e.g.*, Wendy Sword et al., *Women's and Care Providers' Perspectives of Quality Prenatal Care: A Qualitative Descriptive Study*, BMC PREGNANCY 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*, 41 HEALTH AFF. 1477, 1483 (2022).

[22] Willi Horner-Johnson et al., *Perinatal Health Risks and Outcomes Among U.S. Women With Self-Reported Disability*, 41 HEALTH AFFAIRS 1477, 1481 (2022).

early pregnancy detection more difficult[23] and consequently hindering the use of early prenatal care.

Disabled people are also more likely to have unplanned pregnancies. Unplanned pregnancies are associated with a higher risk of significant health complications during pregnancy.[24] Two key factors contribute to these unplanned pregnancies. First, negative perceptions of people with disabilities limit the scope and nature of reproductive education and care available.[25] For example, some health care providers hold the view that people with disabilities cannot or should not have children. In fact, health care 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."[26] 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

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[23] Jenna Nobles, *Menstrual Irregularity as a Biological Limit to Early Pregnancy Awareness,* 119 PROC. NAT'L ACAD. SCI., Jan. 4, 2021, at 1.

[24] Heidi Nelson et al., *Associations of Unintended Pregnancy With Maternal and Infant Health Outcomes: A Systematic Review and Meta-Analysis*, 328 J. AM. MED. ASS'N 1714, 1721, 1725 (2022); Willi Horner-Johnson et al., *Pregnancy Intendedness by Maternal Disability Status and Type in the United States*, 52 PERSP. REPROD. HEALTH 31, 31 (Mar. 2020).

[25] Willi Horner-Johnson et al., *Pregnancy Intendedness by Maternal Disability Status and Type in the United States*, 52 PERSP. REPROD. HEALTH 31, 35–36 (2020).

[26] 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.

planning services, in part because providers and caregivers do not view such services as necessary for disabled people.[27]

Second, people with disabilities are more than three times as likely as non-disabled people to experience sexual assault and rape, which may result in unplanned pregnancy.[28] Moreover, disabled people are more likely than non-disabled people to be raped by family members, caregivers, and close friends.[29] When a disabled person is raped by a family member or caregiver on whom they are dependent for access to medical care, it can create additional barriers to accessing prenatal care.

Beyond these barriers to obtaining care, many people with disabilities face an additional economic barrier to accessing health care. People with disabilities are twice as likely to be poor and more likely to be unemployed as those without disabilities.[30] 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.[31] This is over three times

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[27] *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).

[28] ERIKA HARRELL, U.S. DEP'T OF JUST., CRIME AGAINST PERSONS WITH DISABILITIES, 2009-2014 - STATISTICAL TABLES 4 (Nov. 29, 2016), https://bjs.ojp.gov/content/pub/pdf/capd0914st.pdf.

[29] *See id.* at 6.

[30] Pam Fessler, *Why Disability and Poverty Still Go Hand in Hand 25 Years After Landmark Law*, NAT'L PUB. RADIO (July 23, 2015), https://www.npr.org/sections/health-shots/2015/07/23/424990474/why-disability-and-poverty-still-go-hand-in-hand-25-years-after-landmark-law.

[31] NANETTE GOODMAN ET AL., NAT'L DISABILITY INST., FINANCIAL INEQUALITY: DISABILITY, RACE AND POVERTY IN

the share of non-disabled people.[32] In Idaho, sixty-six percent of disabled adults are not in the workforce, compared with just thirty-six percent of non-disabled adults, and about twenty-eight percent of disabled people aged sixteen or older are below or within 150% of the poverty line, compared to eighteen percent of non-disabled Idahoans.[33]

As a result of the numerous barriers described above, disabled people are less likely to receive adequate preventative medical care. This, in turn, means that pregnant people with disabilities are at greater risk of having dangerous pregnancies that are more likely to require emergency stabilizing treatment in hospitals that EMTALA is intended to protect, including abortion care.

B. Pregnant people with disabilities are particularly likely to need stabilizing abortion care mandated under EMTALA but banned by Idaho Code § 18-622 and similar state statutes.

Beyond the impact of the barriers discussed above, pregnancies can be especially challenging for people with disabilities who have pre-existing complex health care needs that put them at greater risk for pregnancy complications or require additional support. In addition to the social factors that lead to risky

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AMERICA, 16 (2017), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf.

[32] *Id.* at 17.

[33] *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%20noninstitutionalized&g=040XX00US16 (last visited Mar. 25, 2024).

pregnancies, such as lack of access to care, medical interactions between pregnancy and disability increase the likelihood of pregnancy complications. This, in turn, makes it more likely that people with 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.[34] Along with other pregnancy-related complications, pregnant people with disabilities are twenty-three times as likely to develop sepsis (a dangerous inflammatory response to an infection that can result in organ failure and death); six times as likely to develop thromboembolism (blood clots in the lungs or veins of the legs which can result in tissue damage and death); four times as likely to develop severe cardiovascular issues (including heart attacks and other disorders of the heart and blood vessels); nearly three times as 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.[35]

Notably, disabled pregnant people are more likely to experience severe preeclampsia or eclampsia (multi-system pregnancy disorders marked by high blood pressure) and premature rupture of membranes

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[34] 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.

[35] *Id*.

("PPROM") during pregnancy. Pregnant people with disabilities are twice as likely as non-disabled people to develop severe preeclampsia/eclampsia during pregnancy,[36] which can result in seizures, destruction of red blood cells, low platelet count, kidney or liver damage or failure, and stroke,[37] thus increasing the likelihood of placental abruption and hemorrhage.[38] Placental abruption and hemorrhaging often lead to cardiac complications, which are likely to require abortion as emergency medical care.[39] Because people with disabilities are already more susceptible to cardiac complications during pregnancy, preeclampsia and eclampsia are especially dangerous for pregnant people with disabilities.[40] People with disabilities are also fifty-five percent more likely to experience PPROM during pregnancy. PPROM occurs when the amniotic sac around the fetus ruptures early, increasing the risk of infection and potentially causing sepsis or organ failure. Since pregnant people with disabilities experience higher risks of infection and sepsis, they are not only more likely to develop PPROM, but are

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[36] *Id.* at 4–7.

[37] *Preeclampsia,* MAYO CLINIC (Apr. 15, 2022), https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745; Fleisher Decl., J.A. 35–36.

[38] *See FAQs: Bleeding During Pregnancy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Aug. 2022), https://www.acog.org/womens-health/faqs/bleeding-during-pregnancy.

[39] *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).

[40] 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 5.

much more likely to experience extreme consequences of PPROM such as organ failure.[41]

Data also indicate 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 a risk of death, preeclampsia, PPROM, and chorioamnionitis (an infection of the placenta and the amniotic fluid) during pregnancy.[42] 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).[43] 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.[44]

Another way in which disabled people are especially likely to face dangerous pregnancies that require abortion as emergency treatment is that they may be required to suspend treatment for their underlying

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[41] *Id.* at 2, 4–7.

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

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

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

health conditions while pregnant. 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 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 ultimately require stabilizing care that might involve abortion. To remove EMTALA protection for such medically necessary care in deference to state abortion bans would be to place disabled people's health and lives on the line.

C. Without EMTALA's protections, state abortion bans will undermine the medical system in important ways, causing additional harm to people with disabilities.

If EMTALA's protections are not upheld in the face of state abortion bans that criminalize necessary stabilizing treatment, the medical system will be significantly impacted in ways that disproportionately harm disabled people. As other *amici* explain, a

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[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.

conclusion that EMTALA does not preempt state abortion bans will lead to a decline in the quality of care and a physician shortage in these states. Further, even when abortion is the medically indicated stabilizing treatment, physicians will be forced to wait for patients' health conditions to worsen sufficiently to legally justify abortion. The presence of criminal statutes that threaten a doctor's livelihood are likely to chill their willingness to provide an abortion even when abortion care is clearly the medically indicated treatment and is arguably allowed under the Idaho statute. Applying this practice, known as "expectant management," when an emergency abortion is medically indicated is not only contrary to medical training, but also undermines the doctor-patient relationship as it supplants best medical practices and forces providers to withhold necessary treatment in contravention of a patient's best interest. Providers throughout Idaho report denying and delaying care, including by performing extra tests, to ensure compliance with Idaho Code § 18-622—subjecting patients to potentially invasive and medically unnecessary procedures that they may not be able to afford. The briefs of other *amici* discuss this point at greater length. *See, e.g.*, Brief of Respondent at 24–25; Brief of St. Luke's in Support of Respondent, at 16–21; Brief of the American Hospital Association, the Association of American Medical Colleges, and America's Essential Hospitals at 10–16.

Delaying care in emergency situations makes it more likely that a patient will die, with one study finding 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.[46]

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[46] Andrea MacDonald et al., *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, 328 J. AM. MED.

While all emergency situations are unique and present challenges,[47] as described above, people with disabilities are more likely to have complex underlying medical conditions, and thus are more likely to suffer from these delays. By compelling emergency providers to delay treatment for people with disabilities who need abortion care and who already have complex health needs, Idaho's law will be especially deadly for people with disabilities.

Delaying care not only increases a disabled pregnant person's risk of death, but also makes it more likely that a pregnant person's medical care will be unnecessarily traumatic. In Texas, a state with similar abortion restrictions, Elizabeth Weller (born with a physical disability called brachial plexus Erb's palsy) was "excited" when she found out she was pregnant in

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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.americanprogress.org/article/abortion-bans-will-result-inmore-women-dying/.

[47] *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-emergency-exceptions-in-abortion-bans-restrictions (declining to issue a definitive list of conditions that might necessitate abortion care as stabilizing care).

2022.[48] At nineteen weeks into her pregnancy, she experienced PPROM. Her OB-GYN told her that the fetus was too underdeveloped to survive and that if she did not terminate her pregnancy, she could get an infection that would cause her to lose her uterus or even her life. She decided to get an abortion but reported feeling "traumatized" after she was barred from receiving an emergency stabilizing abortion because she "wasn't sick enough to get an abortion."[49] Unable to receive the abortion her OB-GYN deemed necessary, Weller went home and spent three days deteriorating physically, mentally, and emotionally. She vomited consistently, had abdominal pain, and agonized over the fact that her fetus was dying inside of her. When Weller was re-admitted to the emergency room three days later, she was diagnosed with chorioamnionitis, and was finally approved for an abortion. To Weller, the delay felt akin to "punishment" and made the "process of healing worse."[50]

As other *amici* explain, under Idaho Code § 18-622, there will be fewer medical personnel capable of providing care for pregnant people as physicians spend time and resources consulting with legal counsel on the legality of providing emergency medical treatment. Already-scarce OB-GYN providers will leave the state, while recruiting these specialists will become far more challenging. *See, e.g.*, Brief of St. Luke's in Support of Respondent, at 13–20.

The departure of health care providers from Idaho has already begun, creating more medical deserts for

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[48] Affidavit of Plaintiff Elizabeth Weller in Support of Application for Temporary Injunction, *Zurawski v. State of Texas*, No. D-1-GN-23-000968 (Tex. Dist. Ct. Travis Cty. May 22, 2023).

[49] *Id.* at 2.

[50] *Id.* at 4.

reproductive care and further delaying care for patients with all the attendant risks described above. For example, in the fifteen months after Idaho Code § 18-622 went into effect, the state lost twenty-two percent of practicing OB-GYNs, leaving half of Idaho's forty-four counties without access to any practicing obstetricians. Without OB-GYNs, there is no meaningful emergency coverage for pregnancy; two Idaho hospitals have closed their birthing units; a third will close by April 1, 2024, due to its inability to recruit obstetricians; and a fourth is in serious jeopardy of closing.[51] This experience is not limited to Idaho. A study of 2022–2023 medical residency applications found that states with strict abortion bans saw a decline in OB-GYN applications that is more than double the decline for states where there was no abortion ban.[52]

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.[53] Thirty percent of Idaho's counties are classified as maternity care

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[51] IDAHO PHYSICIAN WELL-BEING ACTION COLLABORATIVE, A POST-ROE IDAHO 2 (2024), https://www.idahocsh.org/idaho-physician-wellbeing-action-collaborative (last visited Mar. 25, 2024).

[52] Kendal Orgera et al., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health*, ASS'N AM. MED. COLL., Apr. 13, 2023, https://www.aamcresearchinstitute.org/our-work/data-snapshot/training-location-preferences-us-medical-school-graduates-post-dobbs-v-jackson-women-s-health; 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.

[53] *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 Mar. 25, 2024).

deserts, meaning that they do not have any obstetric providers.[54] Idaho's limited number of reproductive health care professionals and rural environment already guaranteed long travel times to access OB-GYN care; people living in counties with the highest travel times had to travel up to ninety-three miles and 108 minutes, on average, to reach their nearest birthing hospital.[55] 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.[56] 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."[57]

The low numbers of care providers and long distances required to reach care are particularly concerning for patients with disabilities. Public transportation is often unavailable in suburban or rural settings, like Idaho.[58] While the vast majority of Americans travel by personal vehicle, disabled people are less likely to drive and, as a result, often opt to travel less. Many people with disabilities rely on others to drive them to

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[54] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN IDAHO 1 (2023).

[55] *Id.* at 2.

[56] 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.

[57] *Id*.

[58] NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 77 (2009); *see Overview of Idaho*, IDAHO DEP'T OF HEALTH AND WELFARE, https://www.gethealthy.dhw.idaho.gov/overview-of-idaho (last visited Mar. 25, 2024).

their medical appointments.[59] As a result, their ability to obtain timely treatment often depends on the willingness and ability of others to assist with their travel. Consequently, disabled people are significantly more likely to arrive late to medical appointments, miss appointments, or delay their care due to transportation difficulties.[60]

As noted in Section II.A. *supra*, difficulties in coordinating travel lead many disabled people to forgo treatment, increasing the likelihood that they will subsequently need emergency health care at the hospital. Many people with disabilities lack the financial means to afford travel outside the state for necessary emergency abortion care that is banned by state law. According to a 2022 study, thirty-seven percent of American workers surveyed reported that they would struggle to cover an unexpected $400 expense.[61] That rate is likely much higher for pregnant people with disabilities.

Because people with disabilities are more likely to live in poverty, they are less likely to be able to afford out-of-state travel to get emergency abortion treatment (even if they were well enough to travel). The higher rates of poverty experienced by people with

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[59] 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.

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

[61] 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-households-202305.pdf.

disabilities are particularly relevant here, as one of the fastest ways of traveling out of state is via airplane, and the U.S. Bureau of Transportation Statistics reports that in 2023 the average domestic air itinerary cost $380.[62] Of course, in addition to cost, the inaccessibility and other logistical challenges of air travel are common barriers for people with disabilities, even when they are not coping with an emergency medical situation.[63]

Many of these consequences of allowing state abortion bans to negate EMTALA's protections will harm all residents of these states. But for the reasons described above, they create particular difficulties for people with disabilities who reside in these states. The result will be frustration of a key congressional aim underlying the passage of EMTALA—ensuring that all people, and particularly those with disabilities, have access to necessary stabilizing treatment in emergency situations.

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[62] *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 Mar. 25, 2024).

[63] 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 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.travelersunited.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).

CONCLUSION

For the reasons set forth above, the Court should consider the serious harm to people with disabilities that will result if states are permitted to criminalize the necessary stabilizing treatment required under EMTALA. The Court should vacate the stay entered on January 5, 2024 and affirm the district court's order granting the United States' motion for a preliminary injunction.

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APPENDIX

APPENDIX TABLE OF CONTENTS

APPENDIX – *Amici Curiae*

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American Association of People with Disabilities

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Civil Rights Education and Enforcement Center

Disability Rights Advocates

Disability Rights California

Disability Rights Washington

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