Nos. 23-35440 & 23-35450

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

v.

STATE OF IDAHO,
Defendant-Appellant,

v.

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

On Appeal from the United States District Court
for the District of Idaho

BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION, ROBERT WOOD JOHNSON FOUNDATION, NETWORK FOR PUBLIC HEALTH LAW, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AND 134 DEANS AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF APPELLEE SUPPORTING AFFIRMANCE

Andrew London
Jack C. Smith
FOLEY HOAG LLP
Seaport West
155 Seaport Blvd.
Boston, MA 02210
(617) 832-1000

Thomas Barker
Counsel of Record
Kian Azimpoor
FOLEY HOAG LLP
1717 K Street N.W.
Washington, D.C. 20006
(202) 223-1200
tbarker@foleyhoag.com

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), *amici* state as follows:

The American Public Health Association is a non-profit professional association that has no parent and issues no stock.

The Robert Wood Johnson Foundation is a non-profit organization that has no parent and issues no stock.

The Network for Public Health Law is a non-profit organization that has no parent and issues no stock.

The American Medical Women's Association is a non-profit professional association that has no parent and issues no stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST[1]

Amici public health organizations include the American Public Health Association, the Robert Wood Johnson Foundation, the Network for Public Health Law, and the American Medical Women's Association, which is the oldest multispecialty organization dedicated to advancing women in medicine and improving women's health. Collectively, these organizations' members include tens of thousands of public health professionals. The organizational *Amici* advocate for the power of public health law and policy to make communities safer, and they are committed to improving health and health equity in the United States. The members of *Amici* public health organizations have both the lived experience of providing emergency healthcare services and a concrete interest in maintaining the critical nationwide standards imposed by the Emergency Medical Treatment and Labor Act ("EMTALA").

The individual *Amici* are a group of 134 distinguished deans and professors of disciplines spanning the health professions, public health, and health law and policy with deep expertise in policies that promote population health and alleviate

[1] Pursuant to Fed. R. App. P. 29, counsel states that all parties consented to the filing of this brief. Further, no party's counsel authored any part of this brief and no person other than *amici* funded its preparation.

barriers to care. They are identified in the Appendix.[2] Their expertise bears on the issues presented in this appeal, including the vital role played by federal policy in shaping the U.S. health care system, the history, purpose, and text of EMTALA and its implementing regulations, and how Congress used its spending powers to ensure timely, appropriate emergency care for all people in the United States, including pregnant women.

Amici collectively file this brief to assist the Court in its consideration of these extremely important questions by explaining the historical and textual basis for EMTALA's nationwide guarantees and why those guarantees preempt Idaho's contradictory law.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case is about whether a state can legally prohibit pregnant individuals from receiving emergency medical care guaranteed under EMTALA, a historic federal law that ensures no individual who comes to an emergency department in need of emergency medical care is denied treatment. Specifically, EMTALA creates a federal duty applicable to all Medicare-participating hospitals with emergency departments to provide emergency care consisting of screening for the presence of an emergency condition and, if an emergency medical condition is

[2] All individual *Amici* write in their individual capacities and not as representatives of their institutions.

identified, either stabilization care or a medically appropriate transfer to a hospital with specialized capabilities. 42 U.S.C. § 1395dd.

EMTALA expressly preempts state laws that directly conflict with the emergency care obligations it imposes on Medicare-participating hospitals. Idaho Code § 18-622 ("Section 18-622") criminalizes the provision of abortion care in nearly all circumstances. But abortion care may be the necessary stabilizing treatment for pregnant women experiencing certain emergency medical conditions. Thus, where a treating emergency physician determines that abortion is the medically necessary stabilization response to a pregnant patient's medical emergency, EMTALA commands such care. Accordingly, to the extent Section 18-622 forecloses such stabilizing treatment, it must give way to the federal law.

Petitioners mischaracterize EMTALA's text and purpose. From its enactment in 1986, EMTALA emphasized the emergent needs of all individuals with medical emergencies while also identifying one particular emergency circumstance—labor and delivery—as a unique type of emergency that is *in addition to, not in lieu of,* the statute's general emergency protections applicable to all people. The statute includes the term "unborn child" to expand hospitals' considerations in the labor and delivery context, not as a general limitation on the right of pregnant women to receive emergency medical treatment. In this vein, amendments to EMTALA adopted in 1989 eliminated the word "active" from the phrase "active labor" to

extend EMTALA's protections to the full labor period, beginning in its early stages. In doing so, the amendment ensured that, at the earliest stage of labor, a pregnant woman who comes to a hospital seeking emergency care is guaranteed treatment not only for herself but also for her about-to-be-born child. This revision closely aligns with another change made in the 1989 amendments, whereby Congress extended EMTALA's right to medically appropriate transfers to hospitals with specialized capabilities for managing specific complex emergencies, including pregnancies that necessitate delivery in a hospital with neonatal intensive care capabilities.

Appellants—the State of Idaho and its legislature—espouse a revisionist history of EMTALA's "unborn child" language as signaling Congressional intent to place fetal health consideration above the life and health of pregnant women facing medical emergencies. But their reading is contradicted by the fact that—under the constitutional protections recognized by *Roe v Wade*, 410 U.S. 113 (1973) at the time—such a law would have been unconstitutional the day it was enacted.

Finally, Appellants demonstrate a fundamental misunderstanding of emergency care and the operation of emergency departments, in their fearmongering portrayal of emergency departments as potential havens for elective abortions. These critical and resource-limited facilities are not equipped or prepared for non-emergency, elective care and certainly not non-emergent abortion.

Terminating pregnancies is an exceptionally rare event in emergency departments. Moreover, Section 18-622 imposes a chilling effect on a vast range of emergency care for pregnant women, since the loss of a pregnancy may be the unavoidable result of emergency care for non-obstetric emergencies. The statute's harms are not theoretical—women are currently being denied care and risking their health because Section 18-622 has tied providers' hands. The Court should reject such outcomes and recognize the supremacy of EMTALA's clear federal guarantees.

ARGUMENT

I. EMTALA PROTECTS WOMEN THROUGHOUT PREGNANCY, AND NOTHING IN THE SPECIAL STATUTORY PROTECTIONS FOR LABOR AND DELIVERY SUBORDINATES THE HEALTH OF PREGNANT WOMEN TO FETAL HEALTH.

A. The history and purpose of EMTALA demonstrate Congress' intent to protect pregnant women.

Prior to EMTALA's enactment, hospitals regularly turned away indigent patients unable to pay for care, including women in labor. *See, e.g.*, *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975) (infant delivered in refusing hospital's parking lot). Even when patients made it through the door, they were in some cases left to languish untreated. *See, e.g.*, *New Biloxi Hosp., Inc. v. Frazier*, 146 So. 2d 882 (Miss. 1962) (gunshot victim openly bled out in emergency department for two hours before transfer). This practice of "patient dumping" resulted in numerous reports of serious injuries and death resulting from lack of care. *See* T.

M. Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 Annals of Health L. 145, 147-48 (2004).

To reduce patient dumping, several states passed emergency care laws. *See, e.g.,* W. King, *Texas Adopts Stringent Rules on Rights of Poor at Hospitals*, The New York Times (Dec. 15, 1985). However, these state laws were flawed, including inconsistent and inadequate definitions of emergency care that resulted in the refusal of care under the guise of confusion, or that did not extend to situations where the health of the patient, but not their life, was in jeopardy. *See* Karen I. Trieger, *Note: Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U L. Rev. 1186, 1202 (1986); *see also* Thomas L. Stricker, Jr., *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. Rev. 1121, 1125 n. 16 (1992) (collecting state statutes); *see, e.g.*, *Thompson v. Sun City Comm. Hosp.*, 688 P.2d 605, 609-11 (Ariz. 1984) (hospital interpreted state emergency-care statute to permit economic cause for transfer); Ky. Rev. Stat. Ann. §§ 216B.400(1), 216B.990(3) (1982) (statute contained no definition of emergency); R.I. Gen. Laws § 23-17-26(a) (1985) (mandating only "prompt *life saving* medical care treatment" in emergency (emphasis added)).

The case for federal anti-patient dumping legislation was, in part, based on evidence that hospital emergency departments, in the face of inadequate state laws, continued to regularly refuse life-saving care to indigent patients unable to pay. *See* 132 Cong. Rec. E24-02 (1986) (Rep. Stark stating that an article reporting this phenomenon is "one of the reasons that we have been able to include in the reconciliation bill... antidumping language designed to stop hospitals from dumping poor patients on other public and charity hospitals.").

In response to continued reports of hospital emergency departments refusing to treat poor and uninsured patients, including pregnant women, Congress enacted EMTALA in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA 1985"). *The Burden of Health Services Regulation: Hearing Before the Joint Economic Comm. Cong. of the United States*, 108th Cong. 32 (2004) (Rep. Stark stating, "Hospitals routinely turned away poor women in labor until Congress intervened and enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) which prohibited this practice and guaranteed access to emergency care to all people, regardless of their ability to pay"); 131 Cong. Rec. S13903 (Oct. 23, 1985) (Sen. Proxmire identifying "one of the most egregious abuses" as "[t]he refusal of hospitals with emergency rooms to provide emergency treatment for critically ill patients or women in labor"); 131 Cong. Rec. 35814 (Dec. 10, 1985) (Rep. Stark stating, "an estimated 200,000 patients are refused care

at hospital because they cannot afford to pay . . . in my district, in Alameda County CA, the refusal of two private hospitals to treat a desperate, pregnant woman who had no medical insurance resulted in the stillbirth of her baby"); Peter Alshire, *Indigent Health Care Issue Takes Spotlight*, Oakland Tribune (Dec. 29, 1985); 132 Cong. Rec. 218 (Ext. of Remarks Jan. 21, 1986) (Rep. Stark placing Alshire's Oakland Tribune article into the Congressional Record, and highlighting the story of "[a] nine-month-pregnant woman who lost her baby after a three-hour ordeal in which she was turned away from two private hospitals because she couldn't prove she had medical insurance").

EMTALA clarified for all hospitals "public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." 131 Cong. Rec. S13892 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

Treatment of pregnant women—with special consideration for those in labor and delivery—is a central focus of EMTALA's national screening and stabilization guarantees. *See, e.g.*, 42 U.S.C. § 1395dd (statutory title, "Examination and treatment for emergency medical conditions *and women in labor*") (emphasis added); *id.* § 1395dd(e)(1)(B) (defining "emergency medical condition" with specific reference to "a pregnant woman who is having contractions"). The current

text amplifies and further broadens the special protections for women in labor codified in the original statute.

As originally enacted, EMTALA contained explicit guarantees of emergency medical care extending to an "individual" who has "an emergency medical condition or is in active labor." COBRA 1985, Pub. L. No. 99-272, 100 Stat. 82, 164 (1986); *see also id.* at 165 (restricting transfer of individuals who "ha[ve] not been stabilized . . . or [are] in active labor"). The statute originally used the descriptor "active labor," defined as a time in which (1) "delivery is imminent"; (2) "there is inadequate time to effect safe transfer to another hospital prior to delivery"; or (3) "transfer may pose a threat of the health and safety of the patient or the unborn child." *Id.* at 166. Thus, the term "unborn child" appeared entirely in a labor and delivery context, representing a subset of all individuals—including pregnant women—with emergencies. *Id*.

Despite EMTALA's protections, post-enactment reports persisted of hospitals denying emergency care to pregnant patients whose labor had not yet reached the "active" phase. *See*, *e.g., Burditt v. U.S. Dep't of HHS*, 934 F.2d 1362, 1369 (5th Cir. 1991) (interpreting the original reference to "active labor" as limiting EMTALA protections for only "a subset of all women in labor"); Clare Ansberry, *Dumping the Poor: Despite Federal Law, Hospitals Still Reject Sick Who Can't Pay*, Wall St. J. (Nov. 29, 1988) (hereafter "Dumping the Poor")

(describing account of woman who gave birth to a stillborn infant while awaiting transfer); 132 Cong. Rec. 27573 (Nov. 6, 1989) (Rep. Donnelly placing Ansberry's Wall St. Journal article into the Congressional Record).

At the same time, community hospitals reported significant issues with another phenomenon affecting pregnant patients called "reverse dumping," in which hospitals with specialized capabilities refused to accept transfers from community hospitals. *See* Ansberry, *Dumping the Poor*, *supra* (reporting that state officials "are observing a new phenomenon: 'reverse dumping'"); *Patient Dumping After COBRA: U.S. Department of Health and Human Services Response to Complaints*, U.S. Dep't of Health and Human Servs., Off. of Inspector Gen. (Dec. 1, 1988), available at https://oig.hhs.gov/reports/all/1988/patient-dumping-after-cobra-us-department-of-health-and-human-services-response-to-complaints/; Robert C. Patton, *Death and Injury by Delay: Hidden Harm and EMTALA's Reverse Dumping Provision*, Ark. J. of Soc. Change & Pub. Serv. (Sept. 16, 2013), available at https://ualr.edu/socialchange/2013/09/16/death-and-injury-by-delay-hidden-harm-and-emtalas-reverse-dumping-provision/; *see generally St. Anthony's Hosp. v. U.S. Dep't of Health and Human Servs.*, 309 F.3d 680 (10th Cir. 2002) (discussing reverse-dumping phenomenon). This issue, too, was placed squarely before Congress after EMTALA's enactment. *See* 132 Cong. Rec. 27573 (Nov. 6,

1989) (Rep. Donnelly placing Ansberry's *Dumping the Poor* article into the Congressional Record).

Specifically, one common reverse dumping problem involved hospitals with neonatal intensive care units (NICUs) that refused to accept even medically appropriate transfers of women in labor. By 1989, maternal transfer prior to birth was widely recognized as the proper standard of emergency care in high-risk situations. This standard of care was intended to ensure that the birth would take place in a hospital with the advanced facilities and expert staff required in high-risk situations, including the rapid admission of the newborn to a NICU. This advance in the standard of care was the result of research that demonstrated the improved safety and outcomes for a neonatal infant when the mother is transferred to a specialty hospital before delivery, so that no time is lost in transferring a neonatal infant with acute needs. *See* N. Marlow and M.L. Chiswick, *Neurodevelopmental outcome of babies weighing less than 2001g at birth: influence of perinatal transfer and mechanical ventilation*, 63 Archives of Disease in Childhood 1069 (1988); M.O. Lobb & R.W.I. Cooke, *Transfer before delivery on Merseyside: an analysis of the first 140 patients*, 90 British J. of Ob. & Gyn. 338 (Apr. 1983). This research went hand in glove with the trend in the medical field across the 1970s and 80s toward increasingly regionalized systems of perinatal care and efforts to ensure that births occurred in facilities with the appropriate level of specialization

in order to optimize outcomes for women and babies. *See, e.g.*, George M. Ryan, Jr., *Toward Improving the Outcome of Pregnancy*, 46 Ob. & Gyn. J. of Am. Coll. of Obstetricians and Gynecology 375 (Oct. 1975); Marie C. McCormick et al., *The Regionalization of Perinatal Services*, 253(6) J. Am. Med. Ass'n 799-804 (Feb. 1985); Roger A. Rosenblatt et al., *Outcomes of Regionalized Perinatal Care in Washington State*, 149(1) West. J. Med. 98-102 (July 1988). As originally enacted, EMTALA did not adequately account for the then-nascent regionalization trend and the concordant risks raised by post-birth infant transfers to NICUs because the "active labor" mechanism left open the possibility that hospitals with specialized capabilities could refuse to accept such transfers until labor had reached an "active" stage, which in turn significantly narrowed the window of time that a pre-birth transfer could be safely effectuated.

In 1989, Congress adopted a package of amendments to EMTALA that addressed the dangers caused by limiting the protected labor period to "active labor" while failing to protect against "reverse dumping" by hospitals with specialized capabilities. First, Congress amended EMTALA to strike the word "active," thereby expanding special protections to the full labor period. *See* Omnibus Budget and Reconciliation Act of 1989 ("OBRA 1989"), Pub. L. No. 101-239, 103 Stat. 2106, 2249 at § 6211(h)(2)(A)–(E); H.R. Rep. No. 101-386, at 838 (1989) (Conf. Rep.); *see also* 59 Fed. Reg. 32086, 32105 (June 22, 1994)

(HHS noting "that OBRA 89 removed the term 'active labor' from [EMTALA] and included the full range of symptoms that term was intended to include within the scope of the term "emergency medical condition…").

Second, Congress amended the statute to add a duty for facilities with advanced capabilities to accept transfers without discrimination. 42 U.S.C. § 1395dd(g) (the "nondiscrimination" provision). This provision addressed the regionalization and specialization trends, as well as the reverse dumping phenomenon, by mandating that "[a] participating hospital that has specialized capabilities or facilities (such as . . . neonatal intensive care units . . .) shall not refuse to accept an appropriate transfer" as long as the advanced facility had the capacity to treat the individual. *Id.*

Third, Congress expanded the considerations a hospital must assess before transferring a pregnant woman in labor, to include potential harms to the "unborn child." 42 U.S.C. § 1395dd(c)(2)(A); *id*. § 1395dd(e)(1)(B)(ii); *id*. § 1395dd(c)(1)(A)(ii). This consideration facilitates the transfer of women with high-risk pregnancies who are in labor to ensure that both the mother and infant are moved to a facility capable of managing such deliveries, as well as ensuring that infants can be admitted into neonatal intensive care at the moment of birth to avoid a high-risk transfer once born.

These three amendments cohesively closed a prominent gap in EMTALA obligations and facilitated pre-delivery transfers for women with high-risk labor, guaranteeing that the screening and stabilization protections begin at the earliest point of labor and take into account risks to the unborn child, not just risks to the mother, while ensuring that hospitals with specialized NICU facilities cannot turn away the transfer.

B. EMTALA's references to the "unborn child" expand protections during labor and delivery and do not create a wholesale abortion ban.

The history described above demonstrates Congressional intent to expand EMTALA's protections and close gaps in the labor and delivery context, including through the consideration of harm to the "unborn child" as part of hospital duties when a pregnant woman arrives in labor. Nonetheless, Appellants argue that EMTALA's reference to an "unborn child" "demands equal treatment for the unborn child" throughout pregnancy and that EMTALA thus restricts the scope of emergency care to which pregnant women are entitled. Moyle Br. at 45; Idaho Br. at 29-32. This argument is patently false. The plain meaning of the text, as reinforced by the statute's history, forecloses this interpretation.

In three of its four provisions referencing the "unborn child," EMTALA expressly cabins such language to the labor context. The first reference states, "If an individual at a hospital has an emergency medical condition which has not been

stabilized…the hospital may not transfer the individual unless…the medical benefits reasonably expected…outweigh the increased risks to the individual and, *in the case of labor*, to the unborn child from effecting the transfer…" (emphasis added). 42 U.S.C. § 1395dd(c)(1)(A)(ii). Next, "[a]n appropriate transfer to a medical facility is a transfer in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, *in the case of a woman in labor*, the health of the unborn child (emphasis added). *Id*. § 1395dd(c)(2)(A). Third, "[t]he term 'emergency medical condition' means . . . with respect to a pregnant woman *who is having contractions* . . . that transfer may pose a threat to the health or safety of the woman or the unborn child" *Id*. § 1395dd(e)(1)(B)(ii) (emphasis added). These three references to "unborn child" direct hospitals to weigh risks to an "unborn child" when determining whether a pregnant woman in labor may be transferred before delivery. 42 U.S.C. §§ 1395dd(c)(1)(A)(ii), 1395dd(c)(2)(A), and 1395dd(e)(1)(B)(ii). These provisions, specific to labor and delivery, are separate and apart from a hospital's superseding obligation to provide stabilizing treatment to a pregnant woman experiencing an emergency medical condition that poses a serious threat to her health.

Furthermore, the one instance of "unborn child" in the statutory text that is not expressly cabined to labor and delivery must be read in its statutory context, in

light of the statute's purpose and original understanding and in light of the history that prompted the OBRA 1989 amendments. EMTALA defines "emergency medical condition" to include symptoms that would "plac[e] the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy." *Id.* §1395dd (e)(1)(A)(i). Given that three of EMTALA's four provisions referencing the "unborn child" are cabined to the context of labor and delivery, the presumption of consistent usage tells us that the fourth provision that references "unborn child" is presumed to bear the same meaning as the other three provisions in the statute. *See Robers v. United States*, 134 S. Ct. 1854, 1857 (2014) ("[I]dentical words used in different parts of the same statute are…presumed to have the same meaning") (quoting *Merrill Lynch, Pierce, Fenner & Smith Inc. v. Dabit*, 547 U.S. 71, 86 (2006)). By the same token, in accordance with the whole-text cannon, any ambiguity in the import of the phrase "unborn child" in the parenthetical reference at §1395dd (e)(1)(A)(i) must be resolved by reference to the statutory scheme as a whole, including its use of that phrase elsewhere and its concurrent amendment to expand access to neonatal transfers through the nondiscrimination provision. *See United Sav. Ass'n of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme").

This consistent, cohesive understanding of the phrase "unborn child" is the "single, best meaning" of the statute. *See Loper Bright Enters. v. Raimondo*, 144 S. Ct. 2244, 2266 (2024). Rather than subordinating the mother's health in a manner inconsistent with the rest of the statutory scheme, § 1395dd(e)(1)(A)(i) merely ensures that hospitals cannot turn away pregnant patients whose emergencies and high-risk labor, even in its earliest stages, threaten their fetuses'—but not their own—health. And if Congress had sought to prioritize the fetus over the health of the mother, it would not have adopted this wholesale inversion of EMTALA's guarantees in an isolated parenthetical. *Cf. Sackett v. EPA*, 143 S. Ct. 1322 (2023) ("Congress does not hide elephants in mouseholes," nor "fundamental details" in "ancillary provisions"). Each of the four references to the "unborn child" is, thereby, consistent with the statutory intent to expand—not restrict—emergency care access for pregnant women.

Appellants' revisionist position, elevating the phrase "unborn child" to subordinate the treatment of the pregnant woman, runs counter to EMTALA's plain text and history. *Moyle* Br. at 31 (contending "EMTALA does not focus the stabilization duty on the individual, but rather demands that covered hospitals 'stabilize *the medical condition,*' which it expressly defines to include a condition that places 'the health of the . . . unborn child[ ] in serious jeopardy.'") First, as explained above, the historical use of the term "unborn child" in EMTALA's

original provisions and the similar construction that predominates in the OBRA 1989 amendments support reading all textual references to the "unborn child" cohesively, to refer to the labor and delivery context.

Second, Appellants' reading of the "unborn child" language would have rendered the 1989 amendments to EMTALA unconstitutional the day they were enacted. When EMTALA was passed and amended, in 1986 and 1989 respectively, abortion was legal and constitutionally protected in all states. *Roe v. Wade* recognized a federal constitutional right to pre-viability abortion. And the decision treated abortion as a medical procedure to be regulated, specifically with reference to viability and trimesters. But considerations of viability and trimesters are wholly absent from Appellants' revisionist view of the "unborn child" language, such that the phrase's protections under their view would presumably apply at *any* point in a pregnancy. Moreover, by Appellants' logic, any emergency treatment for a pregnant woman that jeopardizes the pregnancy at any stage would be barred, including, *e.g.*, general anesthesia for an auto injury or appendicitis, and many treatments for cancer, heart attacks, or strokes. *See, e.g.*, Peter G. Duncan et al., *Fetal Risk of Anesthesia and Surgery during Pregnancy*, 64 Anesthesiology 790, 790 (1986) (finding "increased risk of spontaneous abortion in those undergoing surgery with general anesthesia in the first or second trimester"); Sol M. Shnider &

Grace M. Webster, *Maternal and fetal hazards of surgery during pregnancy*, 92(7) Am. J. Obstetrics & Gynecology 891-900 (1965).

The Court should not ascribe to legislators the intent to legislate contrary to the Constitution. *See Rust v. Sullivan*, 500 U.S. 173, 191 (1991) ("[W]e assume [Congress] legislates in light of constitutional limitations."); *FTC v. Am. Tobacco Co.*, 264 U.S. 298, 307 (1924); *see also Bostock v. Clayton County*, 590 U.S. 644, 654 (2020) ("This Court normally interprets a statute in accord with the ordinary public meaning of its terms *at the time of its enactment*.") (emphasis added).

Regulations implementing EMTALA provide further evidence in support of the statute's clear meaning. Regulatory interpretation spanning rules issued in 1988, 1994, and 2003 illustrate the contemporaneous and long-held understanding that pregnant women are not subordinate to fetuses. *See* 53 Fed. Reg. 22506, 22513 (June 16, 1998); *see also* 59 Fed Reg. 32078, 32092 (June 22, 1994); 68. Fed Reg. 53222 (Sept. 9, 2003).

First, a 1988 proposed rule issued by the U.S. Department of Health and Human Services (HHS) required a hospital with an emergency department to provide an appropriate medical screening examination and stabilizing treatment to any woman in active labor, without reference to the "unborn child." 53 Fed. Reg. at 22513 (June 16, 1988). Next, in setting requirements for hospitals with emergency departments, a 1994 interim final rule issued by HHS devoted considerable

discussion to the care and safety of a woman in labor without reference to "unborn child." *See* 59 Fed Reg. at 32105 (June 22, 1994). Specifically, the rule states if a woman in labor is having a normal, uncomplicated delivery, a hospital is statutorily required to provide necessary stabilizing treatment—even if it does not have an obstetrical department—or to effect an appropriate transfer to another hospital willing to accept the patient. *Id*. at 32105. The rule also places particular emphasis on signage in emergency rooms that specify they will provide treatment for women in labor, with no mention of the "unborn child." *Id*. at 32127. Lastly, a 2003 final rule issued by HHS discusses protecting women in labor experiencing emergency medical conditions in the context of EMTALA's transfer and stabilization requirements with no mention of the term "unborn child." *See* 68 Fed Reg. 53222 (Sept. 9, 2003).

To be sure, the agency's understanding of the statute does not compel any judicial finding, but "[c]areful attention to the judgment of the Executive Branch may help inform" statutory interpretation. *See Loper Bright*, 144 S. Ct. at 2273. Here, the regulatory history of EMTALA underscores the statute's plain text, historical motivation, and contemporary understanding of protecting pregnant women without Appellants' proposed fetal equivalency.

In sum, the four references to the "unborn child" in EMTALA are limited to emergency care in the context of labor and delivery, including for consideration of

pre-delivery transfer to a facility with advanced NICU capabilities, not a means for excluding pregnant women from the protections of the statute. When a pregnant patient presents an emergency medical condition that threatens her unborn child's health, the hospital owes her the same screening, stabilization, and transfer obligations under EMTALA that it owes any other patient with an emergency medical condition. By the same token, when a pregnant patient presents an emergency medical condition that threatens her health, and pregnancy termination is the recommended path to saving her life or preventing serious harm, the pregnant patient nevertheless qualifies as an individual with an emergency medical condition who is entitled to stabilizing care.

II. EMTALA DOES NOT CONVERT EMERGENCY DEPARTMENTS INTO NON-EMERGENT, ELECTIVE CARE CENTERS FOR ABORTION SERVICES.

Appellants mischaracterize the services of emergency departments, as well as the emergency conditions facing pregnant patients, in raising the specter of elective abortions in these facilities. Appellants contended before the Supreme Court that emergency departments will become "abortion enclaves" if they are permitted to perform abortion procedures as necessary stabilizing treatment under EMTALA. Brief of Petitioner Idaho ("Idaho S. Ct. Br.") 30, *Moyle v. United States*, 144 S. Ct. 2015 (2024). The same misunderstanding, in varying forms, permeates their briefing before this Court. *See, e.g.*, Idaho Br. at 37; Moyle Br. at 22.

Emergency departments, which operate under tremendous constraints, are not organized and operated to furnish non-emergent care. Nonetheless, Section 18-622 threatens *genuine* emergency care both by directly prohibiting such care and by chilling myriad forms of necessary emergency care for non-obstetrical emergencies that could, in fact, carry implications for the continuation of a pregnancy. Further, in limited circumstances, Section 18-622 directly bars care necessary to stabilize pregnant patients, and in so doing, it directly conflicts with EMTALA's federal obligations.

A. Appellants Display a Complete Lack of Understanding of The Conditions Under Which Emergency Medicine Currently Operates as Well as the Scope of Services Provided in Emergency Departments.

On remand, following dismissal of certiorari, Appellants hyperbolically assert that the government's position would open "…a 'mental health' loophole for abortion" *See* Idaho Br. at 37. Appellants continue to advance a distorted vision of abortion and emergency care. *See* Moyle Br. at 22 (suggesting Government's position would permit Congress to ratify "third-trimester elective abortions or eugenic abortions"). Their oddly envisioned position evinces a misunderstanding of what EMTALA requires, how emergency departments operate, and the conditions under which they provide care.

Emergency departments are not available for non-emergent, elective care. An emergency department is "an organized, hospital-based facility for providing

unscheduled or episodic services to patients who present for immediate medical attention." HHS OIG, *Audit of Medicare Emergency Department Evaluation and Management Services*; *see also* ACEP, *Definition of an Emergency Service* (Jan. 2021) ("An emergency service is any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required."). Emergency departments thus serve a vital, but specific, public safety function to screen for and stabilize unplanned and emergent medical conditions.

Today's emergency departments operate under enormous stress and capacity restraints that make it impossible for them to provide services, such as elective or non-emergent abortions, that are outside of their core functions. Notably, the number of emergency department visits is increasing even as the number of emergency departments is decreasing, worsening access. *See* American Hospital Association, *Trendwatch Chartbook* 32 (2018) (finding that, between 1995 and 2016, the number of emergency department visits significantly increased, while the number of emergency departments has steadily decreased). Further, hospitals are experiencing worsening emergency department overcrowding and boarding. *See* S. M. Peterson et al., *Trends and Characterization of Academic Emergency Department Patient Visits: A Five Year Review*, 26(4) Acad. Emerg. Med. 410-419

(Sept. 24, 2018) (finding rising overcrowding nationwide from 2012-2016); G. D. Kelen, *Emergency Department Crowding: The Canary in The Health Care System*, NEJM Catalyst (Sept. 28, 2021) (finding that emergency department patient boarding of 8+ hours rose almost 130% between 2012 and 2019, while instances of 24+ boarding doubled from 2018 to 2019).

Operational stresses have led to a staffing crisis, including fewer emergency department residencies being filled. *See* C. Preiksaitis et al., *Characteristics of Emergency Medicine Residency Programs With Unfilled Positions in the 2023 Match*, 82(5) Annals of Emergency Med. 598 (2023); G. R. Schmitz &, Z. J. Jarou, *The Emergency Medicine Match: Is the Sky Falling or Is This Just Growing Pains?*, 82(5) Annals of Emergency Med. 608 (2023). Emergency physicians are also more likely to experience burnout. *See* T.D. Shanafelt, *Changes in Burnout and Satisfaction with Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017*, 94(9) Mayo Clin Proc. 1681 (Sept. 2019).

Furthermore, the very structure of emergency medicine guarantees that the termination of a pregnancy will be a rare event, undertaken in only the most exigent circumstances. Emergency departments are designed and operated to work under emergency conditions for people with medical emergencies falling within

EMTALA parameters. They do not—and cannot under the typically high-pressure conditions in which they operate—furnish non-emergent care during pregnancy.

Ultimately, abortion rarely falls to emergency department personnel and does so only in exceptionally unusual and tragic cases in which abortion is in fact the professional standard of emergency care to medically stabilize the mother. *See* R. K. Jones & K. Kooistra, *Abortion Incidence and Access to Services in the United States*, *2008*, 43(1) Perspectives on Sexual and Reproductive Health 41, 41-50 (March 2011) ("Many hospitals provide abortions only in cases of fetal anomaly or serious risk to the woman's health, and a majority (65%) performed fewer than 30 abortions in 2008").

For those reasons, the reality is that emergency departments simply do not have the capacity or operational structure to function as the non-emergent, elective care centers that Appellants suggest.

B. Section 18-622 Is Already Disrupting Access to Vital Emergency Care for Pregnant Patients.

EMTALA recognizes that unfettered access to emergency care is crucial for all individuals. However, Appellants' position effectively deprives pregnant women of the ability to seek emergent medical care not involving labor and delivery, regardless of whether their emergency is obstetric or non-obstetric. Indeed, Idaho's attempt to restrict emergency treatment choices for pregnant patients legally

endangers any emergency department that treats emergencies in pregnancy. The devastating effects from these measures are already playing out in hospitals.

The broad scope of pregnancy emergencies provides critical context for realizing the full implications of Section 18-622. "Problems of pregnancy" make up 1.3% of all emergency department visits for women, which comes out to an estimated 1.2 million emergency department visits each year. C. Cairns & K. Kang, *National Hospital Ambulatory Medical Care Survey: 2019 Emergency Department Summary Tables*, Centers for Disease Control and Prevention, National Center for Health Statistics (2022). But *non-obstetric* emergencies are common as well, and their successful treatment can imperil a pregnancy and thus be implicated by Section 18-622. *See* M. T. Coleman, *Nonobstetric Emergencies in Pregnancy: Trauma and Surgical Conditions*, Am. J. Obstet. Gynecol. (Sept. 1997).

Non-obstetrical emergency conditions affect 1 in 500 pregnancies and can include appendicitis, cholecystitis, pancreatitis, and bowel obstruction, all of which affect the abdominal area but can be masked by the physiologic changes that occur in pregnancy, including abdominal girth, elevated serum enzyme levels and problems of adrenal insufficiency. *Id*. Moreover, trauma is the leading non-obstetrical cause of fetal death and occurs in 7% of all pregnancies–caused by motor vehicle accidents, falls, and direct assaults–all of which can require emergency stabilizing care but can increase the risk of fetal loss and rupture of the

placenta. *Id*. Pregnant women also face a risk of non-obstetrical surgery during pregnancy, with surgery related to appendicitis and biliary disease being the most common types of abdominal surgery. *See* E. R. Norwitz & J. S. Park, *Nonobstetric Surgery In Pregnant Patients: Patient Counseling, Surgical Considerations, and Obstetric Management*, UpToDate (Jan. 2024).

Given the myriad conditions that can necessitate emergency stabilizing care for a pregnant woman, the potential harm caused by Section 18-622 cannot be overstated. To be sure, Section 18-622 does not prohibit abortion where "necessary" to prevent the mother's death, and it excludes certain limited circumstances—i.e., "ectopic and nonviable pregnancies"—from Section 18-622's prohibition. *See Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1202-03 (Idaho 2023); Idaho Code § 18- 604(1)(b)-(c) (2023). But these limited circumstances do not encompass the universe of emergency conditions that could require abortion for stabilizing treatment and which present emergent—but not life-threatening—conditions.

Moreover, providers treating women whose emergencies are advanced and require the most aggressive interventions to avert severe and long-lasting physical health impact will inevitably be confronted with the increased risk of fetal loss as an unintended consequence of treatment. Facing these pressures, Idaho's criminal prohibition and penalty create a tension that will naturally lead to an

overdeterrence for physicians that will disrupt medical judgments regarding stabilizing care for pregnant patients. *See, e.g.*, David M. Studdert, et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA (2005) (explaining that many physicians practice "defensive medicine" by, among other things, avoiding "procedures and patients that [a]re perceived to elevate the probability of litigation"); G. Kovacs, MD, MHPE and P. Croskerry, MD, PhD, *Clinical Decision Making: An Emergency Medicine Perspective*, Academic Emergency Medicine 947 (Sep. 1999) ("The emergency physician ... must often make complicated clinical decisions with limited information while faced with a multitude of competing demands and distractions.").

The harms caused to pregnant women by Section 18-622 create precisely the type of danger that EMTALA was designed to avert. Emergency department use for obstetrical emergencies is common during pregnancy. *See* S. Malik et al., *Emergency Department Use in the Perinatal Period: An Opportunity for Early Intervention*, 70(6) Annals of Emergency Medicine 835 (Dec. 2017) (finding that at least a third of pregnant women visit the emergency department during their pregnancy). Complications during pregnancy occur frequently, and rates of pregnancy-related complications are rising. *See* G. Goodwin, et al., *A National Analysis of ED Presentations for Early Pregnancy and Complications:*

Implications for Post-Roe America, Am. J. of Emergency Med., 70, 90–95, (Aug. 2023) (finding that 87% of pregnancy-related emergency department visits include bleeding, including threatened miscarriage, maternal hemorrhage, and spontaneous miscarriage); N. A. Cameron et al., *Association of Birth Year of Pregnant Individuals With Trends in Hypertensive Disorders of Pregnancy in the United States*, *1995-2019*, JAMA Network Open (Aug. 24, 2022) (finding significant increases in hypertension disorders during pregnancy, which is associated with pre-eclampsia). Furthermore, individuals who visit the emergency department during pregnancy are more likely to be vulnerable populations, including adolescents and women of color, as well as more likely to have experienced domestic abuse and to have had delayed access to prenatal care. *See* S. Malik et al., *supra*. The importance of emergency care for obstetrical emergencies is underscored by The American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention (CDC), which, in guidance materials for emergency practice, explain the range of obstetrical emergency conditions that can confront emergency personnel. *See Identifying and Managing Obstetric Emergencies in Nonobstetric Settings*, The American College of Obstetricians and Gynecologists (2023).

By criminalizing one form of treatment for pregnant patients with emergencies, Idaho implicates emergency care for pregnant women that extends

well beyond obstetrical emergencies alone, effectively rendering pregnant patients dangerous to treat out of fear of what could happen if the medically reasonable stabilizing treatment either involves, or else has the potential to cause, an abortion.

Heartbreaking stories from Idaho hospitals demonstrate that these harms are not hypothetical—women are now being denied care because of Section 18-622. *See* Julie Luchetta, *Idaho's biggest hospital says emergency flights for pregnant patients up sharply*, NPR (Apr. 26, 2024), available at https://www.npr.org/2024/04/25/1246990306/more-emergency-flights-for-pregnant-patients--in-idaho (health system had airlifted six patients to other states to receive emergency pregnancy terminations by April 2024 and anticipated 20 such air transport cases within the year). Providers have even been placed in the untenable position of advising pregnant patients to purchase subscriptions with emergency air transport services to avoid costs of transport should emergency termination become necessary. Kelcie Mosely-Morris, *Loss of federal protection in Idaho spurs pregnant patients to plan for emergency air transport*, Idaho Capital Sun (Apr. 23, 2024), available at https://idahocapitalsun.com/2024/04/23/loss-of-federal-protection-in-idaho-spurs-pregnant-patients-to-plan-for-emergency-air-transport/. Reports collecting medical cases since *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215, 232 (2022), in states with abortion bans, including Idaho, detail delays in obtaining care and "preventable complications,

such as severe infection or having the placenta grow deep into the uterine wall and surrounding structures"—all as a result of physicians who reported feeling their "hands were tied." *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, at 4, Advancing New Standards in Reproductive Health (May 2023), available at https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

C. Section 18-622 Prohibits Necessary Care and Creates Obligations that Directly Contravene EMTALA.

Beyond the practical chilling effects of Section 18-622 on providers and patients, the law also creates obligations that contravene federal law by forcing hospitals to withhold abortion care that may be the required stabilizing care under EMTALA.

As the district court correctly found after an extensive factfinding hearing, "it is impossible to comply with both laws." *United States v. Idaho*, No. 22-cv-00329, 2023 U.S. Dist. LEXIS 79235, at *11 (D. Idaho May 4, 2023). The district court identified several circumstances under which the appropriate stabilizing care could encompass abortion, including: infection of the amniotic sac resulting in sepsis, elevated blood pressure or blood clots, and placental abruption. *Id.* at *13-14. These circumstances were not cured by the Idaho Supreme Court's limiting judicial construction of Section 18-622, and the legislature's revisions to its definition of abortion, which only excluded the limited categories of "ectopic and

nonviable pregnancies" from the scope of its prohibition. *See id.* at *14; *Planned Parenthood*, 522 P.3d at 1202-03; Idaho Code § 18-604(1)(b)-(c) (2023). And where presented with such circumstances, where EMTALA mandates the provision of stabilizing abortion care but Section 18-622 would clearly prohibit such care, physicians would be presented with the Hobson's choice of complying with only one competing law. Such a choice is anathema to the Supremacy Clause and thus the subject of fundamental preemption concerns. *See Murphy v. NCAA*, 138 S. Ct. 1461, 1479-80 (2018).

Moreover, nothing in *Dobbs* disturbs this framework of impossible compliance. While *Dobbs* overruled *Roe* and "return[ed] the issue of abortion to the people's elected representatives," 597 U.S. at 232, it did not change the fact that there is an existing, long-standing federal statute—enacted by the people's elected *federal* representatives—guaranteeing a narrow but powerful right to emergency care that tolerates no limits on the ability of physicians to make medically reasonable determinations regarding what treatment may be required in any particular emergency situation. EMTALA's unique federal protection preempts state abortion regulations when they impinge on emergency care.

CONCLUSION

For the foregoing reasons, and those set forth by the Government, this Court should affirm the preliminary injunction and preserve EMTALA's federal guarantees.

Date: October 22, 2024

Respectfully submitted,

/s/ Thoms Barker

Thomas Barker
Kian Azimpoor
FOLEY HOAG LLP
1717 K Street N.W.
Washington, D.C. 20006
(202) 223-1200
tbarker@foleyhoag.com

Andrew London
Jack C. Smith
FOLEY HOAG LLP
Seaport West
155 Seaport Blvd.
Boston, MA 02210
(617) 832-1000

Counsel for Amici Curiae

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 8. Certificate of Compliance for Briefs

9th Cir. Case Number(s) 23-35440 & 23-35450

I am the attorney or self-represented party.

This brief contains 6,996 words, excluding the items exempted by FRAP 32(f). The brief's type size and typeface comply with FRAP 32(a)(5) and (6).

I certify that this brief *(select only one)*:

[ ] complies with the word limit of Cir. R. 32-1.

[ ] is a **cross-appeal** brief and complies with the word limit of Cir. R. 28.1-1.

[X] is an **amicus** brief and complies with the word limit of FRAP 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).

[ ] is for a **death penalty** case and complies with the word limit of Cir. R. 32-4.

[ ] complies with the longer length limit permitted by Cir. R. 32-2(b) because *(select only one)*:
- [ ] it is a joint brief submitted by separately represented parties.
- [ ] a party or parties are filing a single brief in response to multiple briefs.
- [ ] a party or parties are filing a single brief in response to a longer joint brief.

[ ] complies with the length limit designated by court order dated .

[ ] is accompanied by a motion to file a longer brief pursuant to Cir. R. 32-2(a).

Signature */s/ Thomas Barker* **Date** October 22, 2024

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed via the Court's electronic filing system on October 22, 2024, to be served by operation of the electronic filing system on all ECF-registered counsel of record.

/s/ Thomas Barker
Thomas Barker
FOLEY HOAG LLP
1717 K Street N.W.
Washington, D.C. 20006
(202) 223-1200
tbarker@foleyhoag.com

Counsel of Record for Amici Curiae

APPENDIX

APPENDIX TABLE OF CONTENTS

LIST OF AMICI CURIAE

A. Public Health Organizations

1. American Public Health Association

2. Robert Wood Johnson Foundation

3. Network for Public Health Law

4. American Medical Women's Association

B. Public Health Deans

1. Burroughs, Thomas E., PhD, MS, MA, Dean and Professor, SLU College for Public Health and Social Justice, Saint Louis University

2. Deardorff, Julianna, PhD, Executive Associate Dean of Faculty and Academic Affairs and Associate Professor, University of California Berkeley School of Public Health

3. El-Mohandes, Ayman, MBBCh, MD, MPH, Dean, CUNY Graduate School of Public Health & Health Policy

4. Fallin, Daniele, PhD, James W. Curran Dean of Public Health, Rollins School of Public Health, Emory University

5. Fried, Linda P., MD, MPH, Dean and DeLamar Professor of Public Health, Mailman School of Public Health, Professor of Epidemiology and Medicine, Columbia University

6. Galea, Sandro, MD, DrPH, Dean, Robert A. Knox Professor, Boston University

7. Godwin, Hilary, PhD, Dean, University of Washington School of Public Health

8. Goldman, Lynn R., MD, MPH, MS, Michael and Lori Milken Dean of Public Health, Milken Institute School of Public Health, The George Washington University

9. Grogan, Colleen M., PhD, Deputy Dean for Curriculum Policy, Deborah R. and Edgar D. Jannotta Professor, Crown Family School of Social Work, Policy, and Practice, The University of Chicago

10. Gusmano, Michael K., PhD, Professor and Associate Dean of Academic Programs, College of Health, Director, Center for Ethics, Lehigh University

11. Jeffries, Pamela R., PhD, RN, FAAN, ANEF, FSSH, Dean, Vanderbilt School of Nursing, Valere Potter Distinguished Professor of Nursing, RWJF Nurse Executive Fellow Alumna, Vanderbilt School of Nursing

12. Lu, Michael C., MD, MS, MPH, Dean, UC Berkeley School of Public Health

13. Lushniak, Boris, MD, MPH, Professor and Dean, University of Maryland School of Public Health

14. McGovern, Terry, JD, Professor and Senior Associate Dean for Academic and Student Affairs, CUNY School of Public Health

15. Parker, Edith A., MPH, DrPH, Dean, Professor, Community and Behavioral Health, The University of Iowa College of Public Health

16. Petersen, Donna J., ScD, MHS, CPH, Dean, College of Public Health, Professor of Public Health, University of South Florida

17. Ranney, Megan L., MD, MPH, FACEP, Dean, C.-E. A. Winslow Professor of Public Health, Yale School of Public Health

18. Thorpe, Jane, JD, Professor and Sr. Associate Dean for Academic, Student & Faculty Affairs, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

19. Westling, Craig, DrPH, Executive Director of Education, Public Health Education, Geisel School of Medicine at Dartmouth

C. Health Professions, Public Health, Health Law and Policy Scholars

20. Alexander, Andreia B., MD, PhD, MPH, Assistant Professor of Emergency Medicine, Indiana University School of Medicine

21. Alker, Joan, MPhil, Research Professor, McCourt School of Public Policy, Georgetown University

22. Appelbaum, Paul S., MD, Dollard Professor of Psychiatry, Medicine, & Law, Director, Center for Law, Ethics, and Psychiatry, Columbia University Vagelos College of Physicians & Surgeons

23. Ashe, Marice, JD, MPH, Lecturer, University of California Berkeley Law

24. Bard, Jennifer S., JD, MPH, PhD, Professor of Law, College of Law, Professor, Department of Internal Medicine, University of Cincinnati

25. Beckerman, Julia Zoe, JD, MPH, Teaching Professor & Vice Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

26. Blewett, Lynn A., PhD, MA, Professor, Division of Health Policy and Management, University of Minnesota School of Public Health

27. Blumenthal, David, MD, MPP, Professor of Practice of Public Health and Health Policy, Harvard T.H. Chan School of Public Health, Samuel O. Thier Professor of Medicine, Emeritus, Harvard Medical School

28. Bonar, Robert, DHA, Gordon A. Friesen Professor of Healthcare Administration, Director of Master of Health Administration Program, Milken Institute School of Public Health, The George Washington University

29. Borden, William B., MD, FACC, FAHA, Interim Chair, Department of Medicine, Chief Quality and Population Officer, Associate Professor of Medicine and Health Policy, George Washington University Medical Faculty Associates

30. Brindis, Claire D., DrPH, Professor, Departments of Pediatrics and Obstetrics, Gynecology and Reproductive Sciences, Director, Philip R. Lee Institute for Health Policy Studies, Director emeritus and Senior Scholar, Center for Global Reproductive Health, Co- Director, Adolescent and Young Adult Health National Resource Center, Adjunct Professor, UC Hastings School of Law, University of California, San Francisco

31. Burke, Taylor, JD, LLM, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

32. Burris, Scott, JD, Professor of Law, Director, Center for Public Health Law Research, Temple University Beasley School of Law

33. Byrnes, Maureen, MPA, Teaching Instructor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

34. Cartwright-Smith, Lara, JD, MPH, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

35. Catalanotti, Jillian, MD, MPH, FACP, Associate Professor of Medicine, Associate Professor of Health Policy and Management, Director, Internal Medicine Residency Programs, The George Washington University

36. Chavkin, Wendy, MD, MPH, Professor Emerita of Population and Family Health and Obstetrics-Gynecology, Mailman School of Public Health and College of Physicians and Surgeons, Columbia University

37. Chernick, Lauren S., MD, MSc, Associate Professor of Pediatrics in Emergency Medicine, Associate Professor of Population and Family Health, Columbia University Irving Medical Center

38. Clayton, Ellen W., MD, JD, Craig-Weaver Professor of Pediatrics, Professor of Law, Professor of Health Policy, Center for Biomedical Ethics and Society, Vanderbilt University Medical Center and Vanderbilt University

39. Cohen, Alan B., Sc.D., Research Professor (Retired), Markets, Public Policy and Law, Boston University Questrom School of Business, and Professor of Health Law, Policy and Management (Retired), Boston University School of Public Health

40. Collins, Sara R., PhD, Senior Scholar and Vice President, Health Care Coverage and Access and Tracking Health Systems Performance, The Commonwealth Fund

41. Dorfman, Doron, JSD, JSM, LLM, LLB, Professor of Law, Seton Hall University School of Law

42. Estabrook, Alison, MD, FACS, Professor Emerita of Surgery, The Icahn School of Medicine, Mount Sinai Medical Center

43. Evans, Scott, PhD, MS, Director, The Biostatistics Center, Professor and Founding Chair, Department of Biostatistics and Bioinformatics, Milken Institute School of Public Health, The George Washington University

44. Field, Robert I., JD, MPH, PhD, Professor of Law, Thomas R. Kline School of Law, Professor of Health Management and Policy, Dornsife University School of Public Health, Drexel University

45. Fox, Jacqueline, JD, LLM, Professor of Law, Joseph F. Rice School of Law, University of South Carolina

46. Frankford, David M., JD, Professor of Law, Rutgers University School of Law

47. Freed, Salama, PhD, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

48. Friedman, Leonard H., PhD, MPH, FACHE, Professor and Director, MHA@GW Program, Editor, Journal of Health Administration Education, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

49. Freudenberg, Nicholas, DrPH, Distinguished Professor of Public Health, City University of New York

50. Gable, Lance, JD, MPH, Professor of Law, Wayne State University Law School

51. Goldstein, Melissa M., JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

52. Goodwin, Michele, JD, LLM, SJD, Michele Bratcher Goodwin, Linda D. & Timothy J. O'Neill Professor of Constitutional Law and Global Health Policy, Co-Faculty Director, O'Neill Institute, Georgetown Law School

53. Grossman, Daniel, MD, Professor and Vice Chair of Advocacy, Department of Obstetrics, Gynecology and Reproductive Sciences, Director, Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, University of California, San Francisco

54. Halfon, Neal, MD, MPH, Professor of Pediatrics, Public Health and Public Policy, Director, UCLA Center for Healthier Children, Families & Communities, UCLA

55. Hamilton, Bethany, JD, Co-Director, National Center for Medical-Legal Partnership, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

56. Harris, Eva, PhD, Professor and Chair, Division of Infectious Diseases and Vaccinology, School of Public Health, Professor, Division of Immunology and Molecular Medicine, Department of Molecular and Cell Biology, Director, Center for Global Public Health, University of California, Berkeley

57. Heinrich, Janet, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

58. Herbst, Jennifer L., JD, LLM, M.Bioethics, Professor of Law and Medical Sciences, Quinnipiac University School of Law and Frank H. Netter School of Medicine

59. Hermer, Laura, JD, LLM, Professor of Law, Mitchell Hamline School of Law

60. Hoffman, Allison K., JD, Professor of Law, Professor of Medical Ethics & Health Policy, University of Pennsylvania Carey Law School

61. Hoffman, Sharona, JD, LLM, SJD, Professor of Bioethics, Edgar A. Hahn Professor of Law, Co-Director, Law-Medicine Center, Case Western Reserve University School of Law

62. Horton, Katherine, RN, MPH, JD, Research Professor in the Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

63. Ivey, Susan L., MD, MHSA, Professor, Adjunct, Co-PI and Co-Director of Research, Health Research for Action, University of California, Berkeley, School of Public Health

64. Jacobs, Feygele, DrPH, MS, MPH, Professor and Director, Geiger Gibson Program in Community Health, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

65. Jacobson, Peter D., JD, MPH, Professor Emeritus of Health Law and Policy, University of Michigan School of Public Health

66. Johnson, Timothy R.B., MD, FACOG, , Arthur F. Thurnau Professor Emeritus of Obstetrics & Gynecology and Women's & Gender Studies, Center for Bioethics and Social Science in Medicine, University of Michigan

67. Jost, Timothy Stoltzfus, JD, Emeritus Professor, Washington and Lee University School of Law

68. King, Louise P., MD, JD, Assistant Professor, Brigham and Women's Hospital, Director of Research, Minimally Invasive Gynecologic Surgery, Associate Program Director, Fellowship in Minimally Invasive Gynecologic Surgery, Director of Reproductive Bioethics, Center for Bioethics, Co-Director, Ethics, Essentials of the Profession Harvard Medical School, Affiliated Faculty Petrie Flom Center Harvard Law School

69. Kershner, Stacie, JD, Deputy Director, Center for Law, Health and Society, George State University College of Law

70. Ku, Leighton, PhD, MPH, Professor, Department of Health Policy and Management, Director, Center for Health Policy Research, Milken Institute School of Public Health, The George Washington University

71. Landers, Renée M., JD, Professor of Law and Faculty Director, Health and Biomedical Law Concentration and Master of Science in Law, Suffolk University Law School

72. Lantz, Paula, PhD, Interim Associate Director, International Policy Center, James B. Hudak Professor of Health Policy, BA Program Director, Gerald R. Ford School of Public Policy, Professor of Health Management and Policy, University Professor of Diversity and Social Transformation, School of Public Health, University of Michigan

73. Law, Sylvia A., JD, Elizabeth K. Dollard Professor Emerita of Law, Medicine and Psychiatry, NYU Law School

74. Levi, Jeffrey, PhD, Professor Emeritus, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

75. Lillie-Blanton, Marsha, DrPH, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

76. Magnus, Manya, PhD, MPH, Professor and Chair, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

77. Marbin, Jyothi, N., MD, Clinical Professor, Pediatrics, USCF, UC Berkeley

78. Mariner, Wendy K., JD, LLM, MPH, Professor of Health Law, Ethics and Human Rights Emerita, Boston University School of Public Health

79. Markus, Anne R., PhD, MHS, JD, Professor and Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

80. Mason, Diana J., RN, PhD, FAAN, Senior Policy Service Professor, Center for Health Policy and Media Engagement, School of Nursing, The George Washington University

81. McDonnell, Karen A., PhD, Associate Professor and Vice Chair, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

82. McLemore, Monica R., RN, MPH, PhD, Professor, Child, Family and Population Health Department, University of Washington, School of Nursing, Adjunct Professor, Department of Health Systems and Population Health, University of Washington, School of Public Health

83. McNulty, Molly, JD, Associate Professor of Public Health Law and Policy, Undergraduate Program in Public Health, School of Arts and Sciences, University of Rochester, Department of Public Sciences, University of Rochester School of Medicine & Dentistry

84. Michaels, David, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University

85. Minkler, Meredith, DrPH, Professor Emerita of Health and Social Behavior, UC Berkeley School of Public Health

86. Minkoff, Howard, MD, Distinguished Professor Obstetrics and Gynecology SUNY Downstate, Chair Emeritus Maimonides Medical Center and SUNY Downstate

87. Monroe, Anne K., MD, MSPH, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

88. Morello-Frosch, Rachel, PhD, MPH, Professor, Environmental Health Sciences, Professor, Community Health Sciences, Department of Environmental Science, Policy and Management, UC Berkeley School of Public Health

89. Morrison, Jill C., JD, LLM, Visiting Professor of Law, Georgetown University Law Center

90. Musumeci, MaryBeth, JD, Associate Teaching Professor, Milken Institute School of Public Health, The George Washington University

91. Oberlander, Jonathan, PhD, Professor and Chair, Department of Social Medicine, Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill

92. Paltiel, A. David, PhD, Professor of Health Policy and Management, Yale School of Public Health

93. Perez, Adriana, PhD, CRNP, ANP-BC, FAAN, FGSA, Anthony Buividas Term Chair in Gerontology, Associate Professor of Nursing, Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania School of Nursing

94. Perreira, Krista M., PhD, Department of Social Medicine, UNC School of Medicine

95. Peterson, Mark A., PhD, Professor of Public Policy, Political Science, Health Policy and Management, and Law, Department of Public Policy, UCLA Meyer and Renee Luskin School of Public Affairs

96. Pittman, Patricia, PhD, Professor of Health Policy and Management, Director of Health Workforce Research Center, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

97. Regenstein, Marsha, PhD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

98. Reiss, Dorit R., PhD, LLB, Professor of Law, James Edgar Hervey Chair in Litigation, UC Law San Francisco

99. Riegelman, Richard, MD, MPH, PhD, Professor of Epidemiology and Founding Dean, Milken Institute School of Public Health, The George Washington University

100. Rimer, Barbara K., DrPH, MPH, Alumni Distinguished Professor, Dean Emerita, UNC Gillings School of Global Public Health

101. Rohr-Kirchgraber, Theresa, MD, MACP, FAMWA, Professor of Clinical Medicine, Augusta University/University of Georgia Medical Partnership

102. Robertson, Christopher, JD, PhD, N. Neal Pike Scholar and Professor, School of Law, Professor of Health Law, Policy, and Management, School of Public Health, Boston University

103. Rochat, Roger W., MD, Emeritus Professor, Hubert Department of Global Health, Rollins School of Public Health, Emory University, Gynecology and Obstetrics Department, Emory University School of Medicine

104. Rosenbaum, Sara, JD, Professor Emerita, Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

105. Sage, William, MD, JD, Professor of Law, Medicine, and (by courtesy) Government, Associate VP, Health Science Center, Texas A&M University

106. Satz, Ani B., JD, PhD, Professor of Law and Public Health, Director, Project on Health Law, Policy and Ethics, Affiliated Professor of Business, Senior Faculty Fellow, Center for Ethics, Faculty Fellow, Emory Global Health Initiative, Emory University

107. Sawicki, Nadia N., JD, M. Bioethics, Georgia Reithal Professor of Law, Beazley Co-Chair in Health Law, Loyola University Chicago School of Law

108. Schaler-Haynes, Magda, JD, MPH, Professor, Department of Health Policy and Management, Department of Population and Family Health, Columbia University Mailman School of Public Health

109. Schmit, Cason, JD, Assistant Professor, Director, Program in Health Law and Policy, Texas A&M University School of Public Health

110. Schneider, Andy, JD, Research Professor of the Practice, McCourt School of Public Policy, Georgetown University

111. Seiler, Naomi, JD, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

112. Shortell, Stephen M., PhD, MBA, MPH, Distinguished Professor of Health Policy and Management Emeritus and Dean Emeritus, School of Public Health, University of California Berkeley

113. Silberman, Pam, JD, DrPH, Professor Emerita, Director, Executive Doctoral Program in Health Leadership, Department of Health Policy and Management, UNC Gillings School of Global Public Health

114. Siminoff, Laura A., PhD, Laura H. Carnell Professor of Public Health, Department of Social and Behavioral Sciences, Temple University

115. Sinha, Michael S., MD, JD, MPH, FCLM, Assistant Professor of Law, Center for Health Law Studies, Saint Louis University School of Law

116. Skinner, Daniel, PhD, Professor of Health Policy, Ohio University

117. Slifkin, Becky, PhD, Professor Emerita, Department of Health Policy and Management, UNC Gillings School of Global Health

118. Sonenberg, Andréa, PhD, WHNP, CNM-BC, FNAP, FNYAM, Professor Emeritus, College of Health Professions, Pace University

119. Strasser, Julia, DrPH, MPH, Director, Jacobs Institute of Women's Health, Assistant Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

120. Swartzberg, John, MD, FACP, Clinical Professor Emeritus, Professor, Emeriti Academy, School of Public Health, Division of Infectious Diseases and Vaccinology, Chair, Editorial Board, UC Berkeley Wellness Letter, University of California

121. Teitelbaum, Joel, JD, LLM, Professor of Health Policy and Law, Director, Hirsh Health Law and Policy Program, Co-Director, National Center for Medical- Legal Partnership, The George Washington University

122. Tielsch, James M., PhD, Professor and Chair, Department of Global Health, Milken Institute School of Public Health, The George Washington University

123. Ulrich, Michael R., JD, MPH, Associate Professor of Health Law, Ethics, & Human Rights, Boston University School of Public Health, Boston University School of Law

124. Vermund, Sten H., MD, PhD, Anna M.R. Lauder Professor of Public Health, Yale School of Public Health, and Professor of Pediatrics, Yale School of Medicine

125. Vertinsky, Liza, PhD, JD, Professor of Law, University of Maryland Francis King Carey School of Law

126. Vichare, Anushree, PhD, MBBS, MPH, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

127. Vyas, Amita N., PhD, MHS, Professor, Director, Maternal & Child Health Program, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

128. Warren, Keegan, JD, LLM, Executive Director, Institute for Healthcare Access, Texas A&M University Health Science Center

129. Warren-Findlow, Jan, PhD, Professor and Chair, Department of Public Health Sciences, University of North Carolina Charlotte

130. Wasserman, Alan G., MD, MACP, Eugene Meyer Professor of Medicine, Senior Academic Advisor to the Dean, Department of Medicine, The George Washington School of Medicine and Health Sciences

131. Waxman, Judith, JD, Adjunct Professor, Health Law and Policy (2015 – 2021), Milken Institute School of Public Health, The George Washington University

132. Westmoreland, Timothy M., JD, Professor from Practice, Emeritus, Georgetown University School of Law

133. Wisner, Katherine L., MD, MS, Professor of Psychiatry and Pediatrics, The George Washington University, Associate Chief, Developing Brain Institute, Children's National Hospital

134. Young, Heather A., PhD, MPH, Vice Chair/Professor, MPH Epidemiology Codirector/PhD Epidemiology Director, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University