No. 23-1275

In The Supreme Court of the United States

EUNICE MEDINA, INTERIM DIRECTOR,
SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Petitioner,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION, ROBERT WOOD JOHNSON FOUNDATION, NETWORK FOR PUBLIC HEALTH LAW, COUNCIL OF CHAIRS OF OBSTRETRICS AND GYNECOLOGY, JACOBS INSTITUTE OF WOMEN'S HEALTH, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AND 490 DEANS AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS' SUPPORTING AFFIRMANCE

ANDREW M. LONDON
FOLEY HOAG LLP
Seaport West
155 Seaport Blvd.
Boston, MA 02210
(617) 832-1000

BRENNA M. ROSEN
FOLEY HOAG LLP
1301 Ave. of the Americas
New York, NY 10019
(212) 812-4000

THOMAS BARKER
Counsel of Record
KIAN K. AZIMPOOR
FOLEY HOAG LLP
1717 K Street N.W.
Washington, D.C. 20006
(202) 223-1200
tbarker@foleyhoag.com

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INTEREST OF AMICI CURIAE[1]

Amici public health organizations include the American Public Health Association, Robert Wood Johnson Foundation, Network for Public Health Law, Council of Chairs of Obstetrics and Gynecology, Jacobs Institute of Women's Health, and American Medical Women's Association, 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* collectively advocate for the power of public health law and policy to make communities safer and are committed to improving health equity in the United States.

The individual *Amici* are a group of 490 distinguished deans and professors of various health disciplines, law, and policy with extensive expertise in the issues presented in this brief—specifically in policies promoting population health and the alleviation of barriers to healthcare. Individual *Amici* are identified in Appendix 1.[2] With decades of experience among them, *Amici* are well positioned to opine on and place in proper context the consequences of the action at issue in this case.

Amici collectively file this brief to assist the Court in its consideration of the consequences of undermining Medicaid's free choice of provider

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[1] Pursuant to Supreme Court Rule 37.6, counsel represent that they authored this brief in its entirety and no one else made a monetary contribution for it.

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

provision by allowing South Carolina to exclude Planned Parenthood South Atlantic as a Medicaid family planning service provider for reasons unrelated to provider competency.

SUMMARY OF ARGUMENT

For reasons unrelated to provider competency or program fraud or abuse, South Carolina has excluded Planned Parenthood South Atlantic as a Medicaid family planning service provider, thereby depriving women of the ability to receive care from trusted healthcare professionals, with serious implications for their own health and the health of their children. The text of the Medicaid statute, as further evidenced by its history, clearly confers a privately enforceable right to receive services from a beneficiary's qualified family planning provider of choice. The existence of this right is essential in the context of family planning services, where patients require personal and intimate healthcare, and where the ability to select a trusted provider carries profound importance for maternal and child health.

For more than a half century, family planning has been a mandatory Medicaid benefit. Congress has been unwavering in protecting the right of women to freely choose their family planning providers. For example, nearly 40 years ago, even as lawmakers expanded states' authority to require Medicaid beneficiaries to receive services from designated managed care provider networks, Congress amended the free choice of provider statute, 42 U.S.C. §1396a(a)(23) (the "Free Choice of Provider Provision"), to specifically exempt family planning from these otherwise lawful access restrictions and

explicitly preserve beneficiaries' right to obtain family planning services from their provider of choice.

In adding this explicit protection, Congress understood the importance of family planning in promoting the overall health of women and their children. Family planning facilitates the detection and treatment of serious and life-threatening health conditions, such as cancer and sexually transmitted infections, and enables women to plan a safe and healthy pregnancy. The ability to plan a pregnancy reduces infant and maternal mortality by promoting early entry into prenatal care and facilitating comprehensive healthcare throughout pregnancy and childbirth. Women who depend on Medicaid lack financial resources and often live in areas with limited healthcare providers, and the importance of a planned pregnancy only grows as a result.

Failure to preserve Medicaid beneficiaries' free choice of provider protection as a privately enforceable right would allow states, acting for ideological reasons, to strip women of access to qualified and trusted providers for reasons wholly unrelated to the provider's ability to offer high-quality covered services. In states such as South Carolina, which experience high poverty and healthcare provider shortages, allowing officials to pursue such a course of action unchecked would also widen "contraceptive deserts," thereby further threatening beneficiaries' access to family planning services. Over half of South Carolina's counties are medically underserved, and nearly two in five counties are classified as contraceptive deserts. Further, even in regions where there are other qualified providers, there is no evidence that they are in a position to accept a mass

influx of patients who find themselves suddenly without access to the doctors and nurses they know and rely on. For these reasons, South Carolina's exclusion of a qualified provider from its Medicaid program will likely result in severe health consequences for the women who rely on Medicaid for affordable care, as well as their families. Ultimately, undermining the Free Choice of Provider Provision by allowing states to exclude providers for reasons unrelated to their service quality would not only contravene explicit statutory protections that create the Medicaid beneficiaries' right to free choice of family planning providers, but would also have considerable impact on maternal and child health.

ARGUMENT

I. CONGRESS PROMOTED ACCESS TO FAMILY PLANNING BY REPEATEDLY INCLUDING EXPLICIT FREE CHOICE OF FAMILY PLANNING PROVIDER PROTECTIONS IN THE MEDICAID ACT.

A. Medicaid's Free Choice of Provider Provision protects patient autonomy.

Congress has repeatedly and explicitly reinforced Medicaid beneficiaries' right to receive family planning services from their qualified provider of choice. In the early years of the Medicaid program, "Congress grew concerned that states might deny recipients the opportunity to choose the provider of their choice . . . .". *Planned Parenthood S. Atl. v. Kerr,*

27 F. 4th 945, 949 (4th Cir. 2022) (citing *President's Proposals for Revision in the Social Security System: Hearing on H.R. 5710 before the H. Comm. on Ways & Means*, Part 4, 90th Cong. 2273 (1967)).

To address this problem, in 1967, Congress added the Medicaid Free Choice of Provider Provision, 42 U.S.C. § 1396a(a)(23), drafted as an individually conferred right, to (1) protect against a situation in which the government could unilaterally select a healthcare provider for a patient, and (2) protect the ability of qualified providers to participate in Medicaid, while at the same time affirming patient autonomy. Pub. L. 90-248, § 227, 81 Stat. 821, 903-04 (1968). *See President's Proposals for Revision in the Social Security System: Hearing on H.R. 5710 before the H. Comm. on Ways and Means,* 90th Cong. 2273, 2301 (1967) (House Hearings). The Free Choice of Provider Provision dictates that "any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." 42 U.S.C. § 1396a(a)(23)(A). This statutory language ensures that Medicaid beneficiaries have the autonomy to independently choose a trusted provider for their family planning needs and cannot be forced into receiving services from a provider selected by the government.

B. Coverage of comprehensive family planning services is a central feature of Medicaid.

In 1972, seven years after the creation of the Medicaid program, Congress adopted three

significant amendments that cemented the importance of family planning services as a central feature of Medicaid. Social Security Act Amendments, Pub. L. 92-603, § 299E, 86 Stat. 1329 (1972). First, Congress designated family planning services as a mandatory benefit that all state Medicaid programs must offer. *See id.* at 1462; *see also* 42 U.S.C. § 1396d(a)(4)(C) (listing "family planning services and supplies furnished [] to individuals of child-bearing age [] who are eligible under the State plan and who desire such services and supplies" as a Medicaid benefit); *see also* § 1396a(a)(10)(A) (listing medical assistance described in § 1396d(a)(4)(C) as a mandatory benefit). Furthermore, as part of its 1972 amendments, Congress took the additional step of setting an enhanced federal funding level for family planning services and supplies. Pub. L. 92-603, § 299E, 86 Stat. 1329, 1462 (1972). While the federal government generally pays between 50 and 83 percent of the amount state Medicaid programs expend for most covered services, Congress elected to pay for 90 percent of covered family planning services, highlighting the importance of such coverage. 42 U.S.C. § 1396b(a)(5); *see also* 42 U.S.C. § 1396d(b)(1) (stating that the federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum). No other optional or mandatory service category qualifies for this preference, and states' minimal 10% funding obligation for family planning services helps to alleviate the financial burden of covering such services. *See id.* Seeking to improve access to family planning services, Congress acknowledged that "[l]ack of knowledge of and access to family planning services has been a major factor contributing to

unwanted pregnancies" and that "[t]he evidence is clear that these services are desired by recipients and that the information and medical assistance which is made available is utilized." H.R. REP. NO. 92-231, at 143 (1971). *See also* S. REP. NO. 92-1230, at 297 (1972) (stating that by increasing the federal funding percentage, "the committee bill will remove any existing financial barrier to the availability of family planning counseling and services to those desiring those services.").

Congress's intent to promote unrestricted access to family planning is also demonstrated by the 1972 amendment that exempted family planning services from cost-sharing. *See* Pub. L. 92-603, § 208, 86 Stat. 1329, 1381 (1972) ("[N]o enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to [family planning services] will be imposed under the plan . . . ."). Cost sharing indeed serves as a barrier to obtaining necessary health services. *See* Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Rev. of Rsch. Findings*, KAISER FAM. FOUND.(June 2017);[3] *see also 40 Years of the RAND Health Ins. Experiment*, RAND HEALTH.[4] Congress continued to prevent states from requiring enrollees to pay cost-sharing for family planning services when it subsequently amended the Medicaid cost-sharing provisions. *See* Pub. L. 97-248, § 131, 96 Stat. 324, 367-68 (1982); 42 U.S.C. §

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[3] *Available at:* https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[4] *Available at*: https://www.rand.org/health-care/projects/HIE-40.html.

1396o(a)(2)(D); *see also* Pub. L. 109-171, § 6401, 120 Stat. 4, 83 (2006); 42 U.S.C. § 1396o-1 (b)(3)(B)(vii).

These amendments collectively evidence the high importance that Congress placed on access to family planning services.

C. Congress further strengthened Medicaid family planning by expressly specifying beneficiaries' free choice of family planning provider as a right in 1985 and expanding that right in 1987.

Further underscoring Medicaid's guarantee of beneficiaries' full access to family planning services are the protections—specific to family planning and to no other forms of nonemergency healthcare—that Congress explicitly added to Medicaid in 1985 and further strengthened in 1987. Congress has continued to specifically protect beneficiaries' free choice of family planning provider, even as it has otherwise amended federal law to allow states to impose restrictions on beneficiaries' choice of qualified providers by requiring beneficiaries to enroll in managed care plans with limited provider networks. *See Lara Cartwright-Smith & Sara Rosenbaum, Medicaid's Free-Choice-of-Provider Protections in a Fam. Plan. Context: Planned Parenthood Federation of Indiana v. Commissioner of the Indiana State Dept. of Health,* 127 PUB. HEALTH REP. 119, 120 (2012).

As part of the 1985 managed care amendments, Congress considered women's ability to access family planning services from their provider of choice to be of such heightened importance that it created a specific

statutory protection that preserves Medicaid beneficiaries' free choice of family planning provider as an exception to states' new waiver authority to require beneficiaries to enroll in managed care plans with limited provider networks. *See* 42 U.S.C. § 1396n(b); *see also* Pub. L. No. 99-272 § 9508(a)(2), 100 Stat. 82, 211 (1986).

Continued expansion of states' ability to require beneficiaries to enroll in managed care plans with limited provider networks to provide Medicaid-covered benefits prompted Congress to again amend the Free Choice of Provider Provision to protect beneficiaries' unfettered access to family planning services. In 1987, Congress carved out a protection for beneficiaries' free choice of provider for covered family planning services, regardless of whether the beneficiary's chosen provider was in or out of the managed care plan network. Congress amended the statute to state: "[A]n enrollment of an individual eligible for medical assistance in a primary care case-management system [], a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services [for family planning] . . ." 42 U.S.C. § 1396a(a)(23)(B). *See* Pub. L. 100-203 § 4113(c)(1)(B), 101 Stat. 1330, 1330-152 (1987). *see also* H.R. REP. NO. 100-495, 758-59 (1987) ("COBRA provided that, when enrollment [in a Medicaid MCO] occurred under a waiver program, enrollment could not entail any restriction of the freedom to choose a provider of family planning services . . . [the bill] extends to non-waivered enrollment programs the prohibition on any restriction of freedom of choice among family planning providers."). *See also* H.R. REP. NO. 105-149, 19 (1997) ("[t]he restrictions do not

apply to providers of family planning services . . .”). Congress always intended, therefore, that “access to family planning providers could not be restricted” by states, even if states otherwise require beneficiaries to enroll in managed care plans with limited provider networks to obtain other covered services. *Id.* at 589. These special protections in the managed care amendments offer overwhelming evidence of Congress’s focus on Medicaid beneficiaries’ right to access family planning services from their qualified provider of choice.

D. Amendments contained in the Affordable Care Act further underscore that Medicaid beneficiaries have a right to healthcare itself, not merely payment, thereby further elevating the importance of the family planning free choice of provider protections.

Congress’s commitment to enshrining healthcare access as a right, including Medicaid beneficiaries’ free choice of providers in securing that access, continued. As part of the Patient Protection and Affordable Care Act, lawmakers further clarified that the right to medical assistance under the Medicaid program is the right to the services themselves, and not merely the right to payment. 42 U.S.C. § 1396d(a) (“The term ‘medical assistance’ means payment of part or all of the cost of the following care and services or the care and services themselves, or both . . .”). The right to receive covered services necessarily requires access to providers who offer those services. Congress has repeatedly and

explicitly protected beneficiaries' unrestricted access to family planning services. Allowing states to exclude providers for reasons unrelated to their service quality restricts access to covered family planning services.

II. HIGH-QUALITY FAMILY PLANNING SERVICES ARE ESSENTIAL TO MATERNAL AND CHILD HEALTH AND FOUNDATIONAL TO PUBLIC HEALTH.

A. Family planning services significantly improve maternal and child health outcomes by reducing unintended pregnancy.

That Congress would have prioritized beneficiaries' unfettered access to family planning services, including access to all qualified providers that elect to participate in Medicaid, is a reflection of the vast body of research that demonstrates the overriding importance of family planning to the health of women, children, and families. Effective family planning services enable women to properly time and space pregnancy, which is critical to promoting women's health and reducing the risk of poor maternal and child health outcomes. *See e.g.*, Laurel W. Rice et al., *Universal Access to Contraception: Women, Fams., and Cmtys. Benefit*, 222 AM. J. OBSTETRICS AND GYNECOLOGY 150, 150-52 (Feb. 2020); Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 JAMA 1803-23 (Apr. 19, 2006); *Reduce the Proportion of Pregnancies Conceived Within 18 Months of a Previous Birth — FP-02*, U.S.

DEP'T. HEALTH & HUM. SERVS., OFFICE DISEASE PREVENTION AND HEALTH PROMOTION.[5] Despite these advances, continued efforts to facilitate women's access to family planning services is critical, as approximately 42% of pregnancies in the United States today are unintended. *Unintended Pregnancy*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 15, 2024).[6]

Unintended and too-closely-spaced pregnancies significantly increase health risks for mothers and infants, including an elevated risk of infant mortality. A meta-analysis of nearly 70 studies found pregnancies that occur sooner than expected or had birth intervals of less than 18 months increase the risk of low birthweight and preterm births; even if infants survive, they face increased risk of long-term health conditions such as developmental disabilities. Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes,* at 1809; *see also Long-Term Health Effects of Preterm Birth*, MARCH OF DIMES (Feb. 2024);[7] *Preterm Birth*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 8, 2024);[8] *Low*

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[5] *Available at:* https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/reduce-proportion-pregnancies-conceived-within-18-months-previous-birth-fp-02.

[6] *Available at:* https://www.cdc.gov/reproductive-health/hcp/unintended-pregnancy/index.html.

[7] *Available at:* https://www.marchofdimes.org/find-support/topics/birth/long-term-health-effects-preterm-birth#:~:text=Preterm%20birth%20can%20lead%20to,Physical%20development.

[8] *Available at:* https://www.cdc.gov/maternal-infant-health/preterm-birth/index.html#:~:text=Preterm%20birth%20rates,or%20Hispanic%20women%20(10.1%25).

Birthweight, MARCH OF DIMES (June 2021).[9] And birth intervals shorter than six months increase the risk of spontaneous preterm birth by 400%. Laurel W. Rice et al., *Universal Access to Contraception*, at 151. Short interval births also increase the risk of fetal and early neonatal death. Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes,* at 1809.

Unintended pregnancies are associated with delayed entry into prenatal care and interfere with the timely assessment of pregnancy-related health risks. *See* Kai Guterman, *Unintended Pregnancy as a Predictor of Child Maltreatment*, 48 CHILD ABUSE & NEGLECT 160, 161 (2015). Women with unintended pregnancies are less likely to recognize their pregnancies within the first six weeks and schedule a prenatal care visit in the first eight weeks of pregnancy. *See* Kathryn Kost et al., *The Effects of Pregnancy Plan. Status on Birth Outcomes and Infant Care*, 30 FAM. PLAN. PERSP. 223, 223 (1998).[10] Absent or inadequate prenatal care has a statistically significant association with neonatal death, and prenatal care is associated with fewer neonatal deaths in both the presence and absence of antenatal high-risk conditions. Ocilia Maria Costa Carvalho et al., *Delays in Obstetric Care Increase the Risk of Neonatal Near-Miss Morbidity Events and Death: A Case-Control Study*, BMC PREGNANCY AND CHILDBIRTH 1, 5 (2020); Anthony M. Vintzileos et al., *The Impact of*

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[9] *Available at:* https://www.marchofdimes.org/find-support/topics/birth/low-birthweight.

[10] *Available at:* https://www.guttmacher.org/sites/default/files/article_files/3022398.pdf.

Prenatal Care on Neonatal Deaths in the Presence and Absence of Antenatal High-Risk Conditions, 186 AM. J. OBSTETRICS & GYNECOLOGY 1011, 1016 (2002). Optimizing women's access to prenatal care as early as possible in pregnancy is critical to reducing morbidity and mortality and supporting both maternal and fetal health. Rebecca A. Krukowski et al., *Correlates of Early Prenatal Care Access Among U.S. Women: Data from the Pregnancy Risk Assessment Monitoring Sys. (PRAMS)*, MATERNAL AND CHILD HEALTH J. 328, 337 (2022).

Medical and public health experts have concluded that access to high quality, effective contraception is the single most important strategy for reducing the rate of unintended pregnancy and ensuring properly spaced births. A wealth of research supports this finding. The American College of Obstetricians and Gynecologists, *Committee Opinion No. 642: Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, OBSTETRICS & GYNECOLOGY (Oct. 2015). The Centers for Disease Control and Prevention ("CDC"), U.S. Department of Health and Human Services ("HHS") Office of Population Affairs, and HHS Office of Disease Prevention and Health Promotion have all identified the provision of quality family planning services, including comprehensive contraceptive access, as a primary means to address unintended pregnancy. Loretta Gavin et al., *Update: Providing Quality Fam. Plan. Servs. — Recommendations from CDC and the U.S. Office of Population Affairs, 2017*, 66 Ctrs. for Disease Control and Prevention Morbidity and Mortality Weekly

Report 1383, 1383-84 (Dec. 22, 2017).[11] For these reasons, ensuring consistent and reliable access to healthcare services offered by family planning providers is critically important to maternal and infant health.

B. Family planning services reduce the risk of adverse health outcomes and infant mortality that result from untreated sexually transmitted infections.

The benefits of family planning services go beyond ensuring a well-timed pregnancy; they also enable women to identify and address medical risks that can affect their health and the health of their child. Effective family planning includes screening for sexually transmitted infections ("STIs"), such as chlamydia, syphilis, and human papillomavirus ("HPV"), all of which can permanently compromise reproductive and overall health and ultimately cause death. *Sexually Transmitted Infections*, NAT'L INST. ALLERGY INFECTIOUS DISEASES (Apr. 12, 2024);[12] Jennifer J. Frost et al., *Pub. Supported Fam. Plan. Serv. in the U.S.: Likely Need, Availability and Impact, 2016*, GUTTMACHER INST. (Oct. 2019);[13] *The Dangers of Undiagnosed Sexually Transmitted Infections*, AM. SOC'Y OF MICROBIOLOGY (Dec. 8,

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[11] *Available at*: https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm#print.

[12] *Available at*: https://www.niaid.nih.gov/diseases-conditions/sexually-transmitted-infections.

[13] *Available at*: https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf.

2022);[14] *Sexually Transmitted Infections (STIs)*, WORLD HEALTH ORG. (May 21, 2024). [15]

The CDC has attributed a spike in infant mortality to the current STI epidemic in the United States. *Nat'l Overview of STIs in 2023*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 12, 2024);[16] *Selected Nat'ly Notifiable Disease Rates and Number of New Cases: U.S., Selected Years 1950–2018*, CTRS. FOR DISEASE CONTROL AND PREVENTION;[17] *2023 CDC Data Suggest the STI Epidemic May Be Slowing*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 12, 2024);[18] *Table 1. Sexually Transmitted Infections — Reported Cases and Rates of Reported Cases*, U.S.*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 12, 2024).[19] In 2023, over 2.4 million cases of syphilis, gonorrhea, and chlamydia were diagnosed, and congenital syphilis alone led to the deaths or still births of 279 infants. *Nat'l Overview of STIs in 2023*. Furthermore, a 235% increase in congenital syphilis

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[14] *Available at*: https://asm.org/articles/2022/december/the-dangers-of-undiagnosed-sexually-transmitted-in#:~:text=Effects%20on%20Fertility,people%20assigned%20female%20at%20birth.

[15] *Available at*: https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

[16] *Available at*: https://www.cdc.gov/sti-statistics/annual/summary.html#:~:text=In%202023%2C%20over%202.4%20million,1.6%20million%20cases%20of%20chlamydia.

[17] *Available at*: https://www.cdc.gov/nchs/data/hus/2019/010-508.pdf.

[18] *Available at*: https://www.cdc.gov/media/releases/2024/p1112-sti-slowing.html#:~:text=However%2C%20the%20latest%20data%20from,years%20of%20double%2Ddigit%20increases.

[19] *Available at*: https://www.cdc.gov/sti-statistics/data-vis/table-sticasesrates.html.

cases has contributed to at least 149 still births and infant deaths in 2020 and 166 infant deaths in 2021. *Sexually Transmitted Disease Surveillance 2020*, CTRS. FOR DISEASE CONTROL AND PREVENTION;[20] Anna Maria Barry-Jester, *Babies Die as Congenital Syphilis Continues a Decade-Long Surge Across the U.S.*, KAISER FAM. FOUND.(Apr. 12, 2022).[21]

Family planning services play a critical role in addressing health needs that can adversely impact women's maternal and reproductive health. If left untreated, these infections can lead to long term adverse health outcomes, including pelvic inflammatory disease ("PID"), infertility, ectopic pregnancy, and chronic pelvic pain in women. Jennifer J. Frost et al., *Pub. Supported Fam. Plan. Serv. in the U.S.,* at 18.[22] Early treatment of patients who tested positive for chlamydia or gonorrhea helped to prevent more than 12,000 cases of PID, which would have likely resulted in more than 1,000 ectopic pregnancies and 2,000 women becoming infertile. *Id.* at 19. Identifying and treating these conditions also prevents future infections among patients' partners. *See id.* Among women receiving a publicly funded family planning visit, most (72%, or approximately 6.7 million women) otherwise would have forgone STI screenings if they did not have access to publicly funded family planning services, which would have

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[20] *Available at*: https://www.cdc.gov/sti-statistics/media/pdfs/2024/07/2020-SR-4-10-2023.pdf.

[21] *Available at*: https://kffhealthnews.org/news/article/babies-die-as-congenital-syphilis-continues-a-decade-long-surge-across-the-us/.

[22] *Available at*: https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf.

resulted in tens of thousands of undetected and untreated STIs. *Id.*

C. Family planning services help detect and prevent reproductive health conditions that cause infertility or cancer.

Access to family planning services is also critical because contraceptives play a role in preventing several reproductive health conditions that can result in infertility and pain, including endometriosis, PID, cystic disease, and uterine disorders and tumor growth. Adolf Schindler, *Non-Contraceptive Benefits of Oral Hormonal Contraceptives*, INT'L J. OF ENDOCRINOLOGY & METABOLISM 41, 43-46 (Dec. 21, 2012). Specifically, oral contraceptives decrease the risk of PID by 50-60% while also reducing the risk of ectopic pregnancy, length of hospitalizations, amount of medication, and number of operative procedures necessary to treat PID. *Id.* at 44. Similarly, the use of combined estrogen/progestogen oral contraceptives significantly reduces the risk of developing myoma (non-cancerous tumors). *Id.* Oral contraceptives taken long term may protect against the formation of painful ovarian cysts and offer relief from endometriosis and menstrual related symptoms. *Id.* at 42-45.

Research has found that women receiving publicly funded family planning services also receive critical services from their providers in the form of lifesaving detection or prevention of cervical cancer. Jennifer J. Frost et al., *Pub. Supported Fam. Plan.*

Serv. in the U.S., at 9-10.[23] An estimated 1.8 million women were tested for cervical cancer during a publicly funded family planning visit in 2016. *Id.* at 19. Without this care, the vast majority—an estimated 1.3 million women—would have forgone or postponed testing that year. *Id.* Additionally, approximately 39,000 adolescent and young adult women received at least one dose of the HPV vaccine during a publicly supported family planning visit in 2016. *Id.* These vaccinations helped eliminate 4,590 diagnoses of abnormal cervical cells, 920 diagnoses of precancerous lesions, 50 cases of cervical cancer, and 40 cases of other HPV-associated cancers, such as anal or vulvar cancer. *Id.* In total, an estimated 20 cervical cancer deaths were prevented. *Id.* Maintaining access to contraceptive methods, cancer screenings, and other essential reproductive health services is critical to ensuring lifesaving medical care for already marginalized communities. *See id.*

D. Family planning services result in considerable health savings.

The value of family planning services is measurable not only in the immediate and long-term health benefits to women and families, but also in the cost savings associated with preventive services. Research demonstrates that publicly financed family planning services yield billions of dollars in public sector savings. *See e.g.*, Jennifer J. Frost, *Return on Inv.: A Fuller Assessment of the Benefits and Cost Sav. of the U.S. Publy. Funded Fam. Plan. Program*, 92

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[23] *Available at:* https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf.

MILBANK Q. 667, 668 (Oct. 15, 2014);[24] Adam Thomas and Emily Monea, *The High Cost of Unintended Pregnancy*, CTR. ON CHILD. AND FAMS. BROOKINGS INST. 1,4 (July 2011). The estimated gross public savings attributable to the provision of contraceptives, HIV testing, STI testing, HPV testing, Pap testing, and HPV vaccinations in publicly supported family planning settings in 2010 totaled $15.8 billion and $13.6 billion in net public-sector savings after accounting for program costs. *Id.*

III. FAMILY PLANNING SERVICES ARE MOST EFFECTIVE WHEN THEY COME FROM A TRUSTED HEALTHCARE PROVIDER.

A trusting relationship between a patient and their family planning provider is one of the most important factors influencing effective communication, treatment adherence, and health promoting behaviors, especially in the context of sexual wellness and reproductive healthcare. Walid Gellad et al., *A Rev. of Barriers to Medication Adherence: A Framework for Driving Pol'y Options*, RAND HEALTH 1, 6-19 (2009); Kem Krueger et al., *Medication Adherence and Persistence: A Comprehensive Rev.*, 22 ADVANCES THERAPY 313, 331 (2005).[25] It is particularly important for Medicaid beneficiaries to have the ability to choose a family planning service provider they trust. Patients with

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[24] *Available at:* https://pmc.ncbi.nlm.nih.gov/articles/PMC4266172/pdf/milq0092-0667.pdf.

[25] *Available at:* https://www.researchgate.net/publication/7354561_Medication_Adherence_and_Persistence_A_Comprehensive_Review.

limited economic resources, with fair or poor health, or who are racial or ethnic minorities, on average, report having lower trust in healthcare providers compared to the population as a whole. Lea Bart and Sharon K. Long, *QuickTake: Trust in Providers Is Lowest Among Vulnerable Populations*, URB. INST. (Sept. 15, 2017).[26] Medicaid beneficiaries are likely to fall into these categories. *Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION 1, 1-4 (Apr. 2021). Low-income women of color in particular express distrust of healthcare providers due to a history of reproductive health mistreatment, including forced sterilizations. *See e.g.*, Alexandra Minna Stern, *Sterilized in the Name of Pub. Health: Race, Immigr., and Reprod. Control in Mod. Cal.*, 95 AM. J. PUB. HEALTH 1128, 1133 (July 2005); Sally J. Torpy, *Native Am. Women and Coerced Sterilization: On the Trail of Tears in the 1970s*, 24 AM. INDIAN CULTURE AND RSCH. J. 1, 2 (2000). Specifically, Black women describe a heightened awareness of reproductive health inequities, including high rates of Black maternal mortality and considerable experience with substandard and harmful healthcare. Kelly Treder et al., *Racism and the Reprod. Health Experiences of U.S.-Born Black Women*, OBSTETRICS & GYNECOLOGY (Mar. 1, 2022).

A trusting relationship between Medicaid beneficiaries and the family planning provider of their choice plays an essential role in ensuring the medical needs of the most vulnerable populations are

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[26] *Available at:* https://apps.urban.org/features/hrms/quicktakes/trust-providers-lowest-vulnerable-populations.html.

addressed. Compared to other family planning service providers, Planned Parenthood provider staff are more likely to be trained to address the specific needs of the most vulnerable populations, including patients who are adolescents, those who speak a primary language other than English, and those who have experienced intimate partner violence; such training helps to establish trust. *See* Jennifer J. Frost et al., *Variation in Serv. Delivery Pracs. Among Clinics Providing Pub. Funded Fam. Plan. Serv. in 2010*, GUTTMACHER INST. 1, 22 (May 2012).[27]

Trust in the doctor-patient relationship is also associated with increased contraception use and greater adolescent pregnancy prevention. Ariella Tabaac et al., *The Interaction of Sexual Orientation and Provider-Patient Commc'n on Sexual and Reprod. Health in a Sample of U.S. Women of Diverse Sexual Orientations*, 105 PATIENT EDUC. AND COUNS. 1, 3 (Feb. 2022). Trust is essential to ensuring family planning providers avoid intimidating or pressuring women to choose certain contraception options. *See e.g.*, Anu Manchikanti Gomez and Mikaela Wapman, *Under (Implicit) Pressure: Young Black and Latina Women's Perceptions of Contraceptive Care*, 96 CONTRACEPTION 221, 224-25 (Oct. 2017); Kelly Treder et al., *Racism and the Reprod. Health Experiences of U.S.-Born Black Women.* One study found that Black and Latina women discontinued use of contraceptives when they interacted with a family planning provider they did not trust or by whom they felt pressured. Anu Manchikanti Gomez and Mikaela Wapman, *Under*

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[27] *Available at:* https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

(Implicit) Pressure, at 223-24. Notably, such implicit pressure was longitudinally harmful, impacting their future interactions with healthcare providers and leading to reluctance around subsequent contraceptive use. *Id.* at 224. The implications can be pronounced as these experiences can directly contribute to racial and ethnic minority patients avoiding care, disengaging from healthcare interactions, and exercising vigilance in anticipation of mistreatment. *Id.* Ultimately, distrust of providers among vulnerable populations interferes with patient-provider communications and could exacerbate healthcare disparities. *See* Lea Bart and Sharon K. Long, *QuickTake: Trust in Providers.*

IV. EXCLUDING A FAMILY PLANNING PROVIDER FROM MEDICAID FOR REASONS WHOLLY UNRELATED TO THE QUALITY OF CARE WILL WORSEN HEALTHCARE ACCESS AND HARM BENEFICIARIES.

A. Contraceptive and maternity care deserts already exist and are likely to worsen with fewer family planning providers offering services.

When qualified family planning providers are excluded from Medicaid, contraceptive and maternity care deserts are likely to spread. Approximately 19 million women in the U.S. who need publicly funded contraception already live in a "contraceptive desert"

as of 2022. *Contraceptive Deserts*, POWER TO DECIDE.[28] This designation refers to counties in which the number of healthcare providers offering the full range of contraception methods listed in the FDA's Birth Control Guide is insufficient to meet the needs of women who depend on publicly funded contraceptive care. *See id.; see also Birth Control Guide (Chart),* FDA (listing, *inter alia*, IUDs, injectables, vaginal rings, and oral contraceptives as options).[29] In any given state, between 17 percent and 53 percent of the population resides in a contraceptive desert. Rebecca J. Kreitzer et al., *Affordable but Inaccessible? Contraception Deserts in the U.S.*, 46 J. HEALTH POLIT. POL'Y L. 277, 297 (2021); Rebecca J. Kreitzer et al., *Contraceptive Deserts: The Effects of Title X Rule Changes on Access to Reprod. Health Care Res.*, 18 POL. & GENDER 672, 699-704 (2022).

This problem is particularly acute in South Carolina, where most low-income women of reproductive age live in a county that cannot meet the population's demand for the full range of contraceptive methods. To provide context, an estimated 310,100 South Carolina women live in contraceptive deserts. *Contraceptive Access in S.C. (2022)*, POWER TO DECIDE.[30]

Furthermore, Medicaid beneficiaries in South Carolina have less access to contraception providers

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[28] *Available at:* https://powertodecide.org/what-we-do/contraceptive-deserts.

[29] *Available at:* https://www.fda.gov/media/150299/download.

[30] *Available at:* https://powertodecide.org/sites/default/files/2022-11/State%20Factsheet_South%20Carolina.pdf.

compared to most other states. *U.S. Medicaid Contraception Workforce Tracker*, FITZHUGH MULLAN INST. FOR HEALTH WORKFORCE EQUITY (2024).[31] South Carolina falls in the fourth tier (out of five tiers among states with reliable data) for Medicaid beneficiaries' access to all the major contraceptive methods (pill, patch, and/or ring; IUD; and implant). *Id.*

Moreover, the problem of contraceptive deserts in South Carolina is compounded by the prevalence of "maternity care deserts," counties with insufficient access to maternal healthcare, thereby worsening the health risks facing women who experience unintended pregnancies. *Where You Live Matters: Maternity Care in S.C.*, MARCH OF DIMES, 1-3 (2023).[32] Nearly 40% of South Carolina's counties have low or no maternity care access. *Id*. Additionally, over half of South Carolina's counties are medically underserved, *see* S. Gareau et al.*, How Data Drives Action: S.C. Maternal Health Data Snapshot*, INST. FAMS. SOC'Y, UNIV. S.C., COLUMBIA, S.C. (2024) (PDF),[33] and South Carolina ranks 37th in the U.S. for the number of primary care physicians per capita, placing it in the bottom 25% of all states. *See Primary Care Providers in S.C.*, AM. HEALTH RANKINGS (2024).[34] South Carolina also has

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31 *Available at:* https://www.gwhwi.org/medicaid-tracker-contraception-workforce.html.

32 *Available at:* https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-SouthCarolina.pdf.

33 *Available at:* https://img1.scdhhs.gov/presentations/SC%20Maternal%20Health%20Health%20Data%20Snapshot%20%20SCBO.pdf.

34 *Available at:* https://www.americashealthrankings.org/explore/measures/PCP_NPPES/SC.

one of the top five highest "maternal vulnerability" rates in the U.S., informed by six themes: (1) reproductive healthcare; (2) physical health; (3) mental health; (4) general healthcare; (5) socioeconomic determinants; and (6) physical environment. *See Maternal Vulnerability in the U.S. – A Shameful Prob. for One of the World's Wealthiest Cntys.*, SURGO VENTURES.[35]

Maternity care and contraceptive deserts require people to seek care outside their communities, thereby imposing significant burdens and potentially deterring them from seeking services altogether. Transportation to medical care is already a significant barrier for low-income Medicaid beneficiaries. *See* S.T. Syed et al., *Traveling Towards Disease: Transp. Barriers to Health Care Access*, 38 J. COMM'Y HEALTH 976, 976-93 (2013). Increased distances to clinics correlate with decreased utilization of preventive care. *See* Yao Lu & David J.G. Slusky, *The Impact of Women's Health Clinic Closures on Preventive Care*, 8 AM. ECON. J. APP. ECON. 100, 120 (July 2016). All these problems are likely to worsen if states are permitted to exclude providers from their Medicaid programs for reasons wholly unrelated to the quality of their covered family planning services.

B. Planned Parenthood is crucial to increasing access to family planning services.

Planned Parenthood, the healthcare provider singled out for exclusion from South Carolina's Medicaid program in this case, plays an essential role

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[35] *Available at:* https://mvi.surgoventures.org/.

in increasing access to family planning services. In addition to family planning services, Planned Parenthood provides a full range of preventive services, including cancer screenings, anemia testing, cholesterol and diabetes screening, high blood pressure screening, menopause treatment, smoking cessation, testicular and prostate cancer screening, thyroid screening, and vaccines.[36] *See Our Services*, PLANNED PARENTHOOD.[37] To the extent Petitioner is concerned with the cost of Medicaid, Opening Brief for Petitioner at 53, *Medina v. Planned Parenthood* (2025) (No. 23-1275), it fails to recognize healthcare costs only increase without preventive care to protect against avoidable maternal health conditions. *See* Norman J. Waitzman, *Preterm Birth Lifetime Costs in the U.S. in 2016: An Update*, 45 SEMIN. PERINATOLOGY 1, 4 (2021) (unpublished manuscript) (stating that preterm births cost billions of U.S. dollars).

Planned Parenthood clinics also provide extended hours and shorter wait times compared to other family planning clinics, which are necessary to facilitate medical visits for Medicaid beneficiaries working low-wage hourly jobs with minimal flexibility. *See* Frost., *Variation in Serv. Delivery Pracs.,* at 19. Planned Parenthood optimizes health outcomes by offering preventive care and streamlines services by offering HIV rapid-result testing and a wider range of contraceptive options than other family planning clinics, reducing the need for follow-up visits

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[36] The Charleston Planned Parenthood does not appear to offer testicular or prostate screening, menopause treatment, or diabetes screening.

[37] *Available at:* https://www.plannedparenthood.org/get-care/our-services.

or referrals. *See id*. at 19, 10, 27; *see also* Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Fam. Plan. Safety Net*, 20 GUTTMACHER POL'Y REV. 12, 13 (2017). For example, Planned Parenthood clinics are significantly more likely than other clinics to provide a long-acting reversible contraceptive such as an intrauterine device, with nearly all centers offering same-day insertion. *See* Hasstedt, *Understanding Planned Parenthood's Critical Role*, at 13. Research further demonstrates that Planned Parenthood has successfully reduced visit wait times to levels significantly below those of other clinics offering family planning services to Medicaid beneficiaries. *See* Frost, *Variation in Serv. Delivery Pracs.*, at 19; *see also* Mia R. Zolna & Jennifer J. Frost, *Publicly Funded Fam. Plan. Clinics in 2015: Patterns and Trends in Serv. Delivery Pracs. and Protocols*, GUTTMACHER INST. 1, 9 (November 2016).[38]

South Carolina's incorrect assertion that disqualifying Planned Parenthood would ensure that state Medicaid funding would go toward "improving access to necessary medical care," Opening Brief for Petitioner at 11, *Medina v. Planned Parenthood* (2025) (No. 23-1275), is plainly illogical. Research has shown that excluding Planned Parenthood as a family planning provider dramatically reduces women's access to services. For example, the exclusion of Planned Parenthood clinics from the Title X program, due to a 2019 regulatory change, had a disproportionate effect on contraceptive access among

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[38] *Available at:* https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf.

low-income, uninsured, and women of color accessing Title X services. *See* Candis Watts Smith et al., *Contraception Deserts: The Effects of Title X Rule Changes on Access to Reprod. Health Care Res.*, 18 POL. & GENDER, 672, 696–704 (2022). Specifically, following the implementation of the 2019 rule, 573,650 fewer patients under 100 percent of the federal poverty level received Title X services, along with 324,776 fewer uninsured patients, 128,882 fewer Black or African Americans, 269,569 fewer Hispanics/Latinos, and 151,375 fewer adolescent patients. 86 Fed. Reg. 56146-47 (Oct. 7, 2021).

Another example comes from Texas, which excluded Planned Parenthood from its state-funded family planning program in 2012, leading to a marked decline in access to the most effective contraception and a concomitant increase in births covered by Medicaid. A.J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEW ENG. J. MED. 853, 858 (2016) (stating that the exclusion of Planned Parenthood reduced claims for long-acting reversible contraception methods by over 35%).

C. South Carolina's arguments that adequate alternate family planning providers exist are unavailing.

South Carolina's claim that the state's Medicaid beneficiaries have access to "dozens of medical clinics that accept Medicaid and offer a broad panoply of health services" is highly misleading. Opening Brief for Petitioner at 9, *Medina v. Planned Parenthood* (2025) (No. 23-1275). Its infographic includes "pregnancy centers," described as ". . .

privately funded and focused on supporting pregnant women facing difficult circumstances with medical care and referrals, education, mentoring, and material support." *Women Have Real Choices,* CHARLOTTE LOZIER INST.[39] Crisis pregnancy centers, however, are not equipped to offer the full range of family planning methods. *See* Andrea Swartzendruber et al., *Sexual and Reprod. Health Servs. and Related Health Info. on Pregnancy Res. Ctr. Websites: A Statewide Content Analysis*, 28 WOMEN'S HEALTH ISSUES 14, 16-17 (2018). Moreover, the need for increased access to family planning services in South Carolina is substantial: compared to other states, South Carolina ranks 45th for low birth weight. *See Low Birth Weight in S.C.*, AM. HEALTH RANKINGS (2024).[40] Ten percent of infants in South Carolina were born with low birthweight in 2022. *Id.*

Petitioner's infographic also includes community health centers, which research shows have a limited ability to furnish the full range of family planning services, including long-acting reversible contraceptives, the most effective forms of contraception. *See* Susan Wood, et al., *Health Ctrs. and Fam. Plan.: Results of a Nationwide Study*, (March 7, 2013) (PDF);[41] *see also*, e.g., Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 NEW ENG. J. MED. 1998, 2004 (2012). This is likely because community health

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39 *Available at:* https://lozierinstitute.org/realchoices/.

40 *Available at:* https://www.americashealthrankings.org/explore/measures/birthweight/SC.

41 *Available at:* https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1059&context=sphhs_policy_facpubs.

centers' mission is much broader than just family planning: they are charged with providing a full range of primary care to medically underserved patients of all ages, from newborns to seniors. 42 U.S.C. § 254b(a)(1).

Community health centers are also overwhelmed with patients and may be unable to accept new patients. *See Cmty. Health Ctrs. and Fam. Plan. in an Era of Pol'y Uncertainty*, KAISER FAM. FOUND.(March 15, 2018);[42] Letter from Rachel Benson Gold, Vice President for Pub. Pol'y, Guttmacher Inst., to Office of Population Affairs, U.S. Dep't of Health & Human Servs. (July 31, 2018) (stating that South Carolina community health centers would experience a 381% increase in their contraceptive caseload if required to serve all patients of federally funded family planning program clinics). Community health centers' limited ability to meet the full extent of the need for family planning services is illustrated by the fact that Planned Parenthood has provided care for at least half of the women who rely on safety net family planning providers in more than half of the counties where it operates. *See* Hasstedt, *Understanding Planned Parenthood's Critical Role*, at 14.

South Carolina, in fact, needs both Planned Parenthood and community health centers to ensure sufficient access to family planning services for Medicaid beneficiaries. A survey across thirteen states revealed that 60% of respondents preferred to receive contraceptive care from a specialized family

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[42] *Available at:* https://www.kff.org/womens-health-policy/report/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty/.

planning service provider even though they had seen a different provider within the same year, and 40% considered specialized family planning clinics their sole source of healthcare during the year. *See* Jennifer J. Frost et al., *Specialized Fam. Plan. Clinics in the U.S.: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 WOMEN'S HEALTH ISSUES, e519, e524 (2012). Ultimately, Petitioner's arguments about adequate alternatives are inapposite and serve only to obfuscate what this case is about. The issue here is not whether there are workable alternatives to Planned Parenthood, but instead whether women have an enforceable right to protect their choices regarding healthcare access from arbitrary and harmful state action.

CONCLUSION

For the foregoing reasons, the Court should recognize a Medicaid beneficiary's right to obtain family planning services from their qualified provider of choice and affirm a beneficiary's right to enforce the Free Choice of Provider Provision.

Respectfully submitted.

ANDREW M. LONDON
FOLEY HOAG LLP
Seaport West
155 Seaport Blvd.
Boston, MA 02210
(617) 832-1000

BRENNA M. ROSEN
FOLEY HOAG LLP
1301 Ave. of the Americas
New York, NY 10019
(212) 812-4000

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

Counsel for Amici Curiae

March 12, 2025

APPENDIX

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LIST OF *AMICI CURIAE*

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LIST OF *AMICI CURIAE*

A. Public Health Organizations

American Public Health Association

Robert Wood Johnson Foundation

Network for Public Health Law

American Medical Women's Association

The Council of Chairs of Obstetrics and Gynecology

Jacobs Institute of Women's Health

B. Public Health Deans

1. Campbell, Amy T., JD, MBE, Associate Dean for Law & Health Sciences, Professor of Law, School of Law, University of Illinois Chicago

2. Caughey, Aaron B., MD, MPH, PhD, Professor and Chair, Department of Obstetrics & Gynecology, Associate Dean for Women's Health Research & Policy, Oregon Health & Science University

3. Chemerinsky, Erwin, JD, Dean and Jesse H. Choper Distinguished Professor of Law, University of California, Berkeley School of Law

4. Dorcelus, Sandy, DO, FACOG, Assistant Dean of Diversity and Inclusion, NYU Long Island School of Medicine, Assistant Clinical Professor, Department of Obstetrics and Gynecology, NYU Langone Health Long Island

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

6. Ettner, Susan L., PhD, Dean Emerita of Graduate Education, Distinguished Professor, David Geffen School of Medicine, Division of General Internal Medicine and Health Services Research; Distinguished Professor, Fielding School of Public Health, University of California, Los Angeles

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

8. Garrison, Anne, MD, Interim Associate Dean for Student Affairs, Assistant Dean for Professional Development, Associate Director, Division of General OBGYN, Assistant Professor of OBGYN, University of Massachusetts Medical School, UMass Memorial Medical Center

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

10. Harvey, S. Marie, DrPH, MPH, OSU Distinguished Professor of Public Health, Associate Dean for Research, College of Public Health and Human Sciences, Oregon State University

11. Healton, Cheryl, DrPH, Founding Dean and Professor of Public Policy, NYU School of Global Public Health

12. Hyder, Adnan, MD, MPH, PhD, Senior Associate Dean for Research, Professor of Global Health Milken Institute School of Public Health, The George Washington University

13. Jain, Atul, MD, MS, Chair (Interim), Division of General Internal Medicine, Associate Dean, Mayo Clinic School of Continuous Professional Development, Assistant Professor of Medicine, Mayo College of Medicine

14. Klag, Michael J., MD, MPH, Dean Emeritus, Second Century Distinguished Professor, Johns Hopkins Bloomberg School of Public Health

15. Lane, Susan, MD, MACP, Professor of Medicine, Vice Chair of Education, Department of Medicine; Associate Dean for Clinical

Faculty Development, Renaissance School of Medicine at Stony Brook

16. LaVeist, Thomas A., PhD, Dean and Professor, Tulane University School of Public Health and Tropical Medicine

17. Lee-Parritz, Aviva, MD, Chief, Department of Obstetrics and Gynecology, Boston Medical Center, Chair and Associate Professor of Obstetrics and Gynecology, Assistant Dean of Faculty Practice, Boston University School of Medicine

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

19. MacKenzie, Ellen J., PhD, Dean, Bloomberg Distinguished Professor, Johns Hopkins Bloomberg School of Public Health

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

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

22. Rebouché, Rachel, JD, LLM, Kean Family Dean, Peter J. Liacouras Professor of Law, Temple University Beasley School of Law

23. Rupp, Leila J., PhD, Interim Anne and Michael Towbes Graduate Dean, Distinguished

Professor of Feminist Studies, University of California, Santa Barbara

24. Sentell, Tetine, PhD, Interim Dean, Professor of Public Health, Thompson School of Social Work and Public Health, University of Hawai'i at Mānoa

25. Sommer, Alfred, MD, Dean Emeritus, Professor, Johns Hopkins Bloomberg School of Public Health

26. 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

27. Vermund, Sten H., MD, PhD, Dean, College of Public Health, University of South Florida

28. Wilensky, Sara E., JD, PhD, Assistant Dean for Undergraduate Education, Director, Undergraduate Program in Public Health, Special Services Faculty for Undergraduate Education, Milken Institute School of Public Health, The George Washington University

29. Young, Heather M., PhD, RN, FAAN, Professor and Dean Emerita, Betty Irene Moore School of Nursing, University of California, Davis

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

30. Abernathy, Alice, MD, MSHP, Assistant Professor of Obstetrics & Gynecology and Medical Ethics & Health Policy, Perelman School of Medicine, University of Pennsylvania

31. Akman, Jeffrey S., MD, Walter A. Bloedorn Professor of Administrative Medicine and Interim Chair, Department of Psychiatry and Behavioral Sciences, School of Medicine and Health Sciences, The George Washington University

32. Alterman, Amy E., PhD, MPH, Postdoctoral Fellow, Georgetown-Howard Center for Medical Humanities and Health Justice

33. Altshuler, Anna, MD, MPH, Obstetrician/Gynecologist, Researcher, Medical Director, Sutter Health, California Pacific Medical Center, Mission Bernal Women's Clinic

34. Andrinopoulos, Katherine, PhD, Associate Professor, Director of Doctoral Program, Department of International Health and Sustainable Development, Tulane School of Public Health and Tropical Medicine

35. Arnold, Robert M., MD, Vice Chair of Professional Development, Gerald J. and Dorothy R. Friedman Chair in Palliative Care at the Icahn School of Medicine at Mount Sinai,

Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai

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

37. Atalay, Alev J., MD, Instructor of Medicine, Harvard Medical School; Director of Ambulatory Education, Brigham and Women's Hospital

38. Attanasio, Laura, PhD, Assistant Professor, School of Public Health and Health Sciences, University of Massachusetts Amherst

39. Atzinger, Carrie, MS, LGC, CGC, Co-Director, Associate Professor, University of Cincinnati Genetic Counseling Graduate Program

40. Autry, Amy (Meg), MD, Professor, Vice Chair of GME and CME, Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco

41. Baird, Sarah, PhD, Professor and Vice Chair, Department of Global Health, Milken Institute School of Public Health, The George Washington University

42. Baker, Carrie N., JD, PhD, Sylvia Dlugasch Bauman Chair of American Studies, Professor, Program for the Study of Women and Gender, Smith College

43. Balkus, Jennifer, PhD, MPH, Clinical Associate Professor, University of Washington School of Public Health

44. Barbieri, Robert L., MD, Chair, Department of Obstetrics and Gynecology, Brigham and Women's Hospital

45. Barkoff, Alison, JD, Professor, Harold and Jane Hirsh Associate Professor of Health Law and Policy, Director, Hirsh Health Law and Policy Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

46. Bartz, Deborah, MD, MPH, Assistant Professor of Obstetrics and Gynecology, Harvard Medical School

47. Beaman, Jessica, MD, MPH, Assistant Professor, Department of Medicine, University of California, San Francisco

48. 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

49. Belanoff, Candice, ScD, MPH, Clinical Associate Professor, Boston University School of Public Health

50. Bell, David L., MD, MPH Professor, Department of Pediatrics, Department of

Population and Family Health, Columbia University Irving Medical Center

51. Bell, Suzanne, PhD, MPH, Associate Professor, Department of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

52. Belmonte, Michael A., MD, Complex Family Planning Fellow, University of Colorado

53. Bender Ignacio, Rachel, MD, MPH, Associate Professor, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington

54. Benfield, Nerys, MD, MPH, Chief Medical Officer for Adult Services and Vice Chair for Quality and Safety in the Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco

55. Benson, Lyndsey, MD, MS, Assistant Professor, Division of Complex Family Planning, Department of Obstetrics and Gynecology, University of Washington

56. Bercu, Chiara, MPA, Senior Project Manager, Ibis Reproductive Health

57. Berlin, Michelle, MD, MPH, Professor, Oregon Health & Sciences University Department of Obstetrics & Gynecology and Portland State University School of Public Health (Emerita),

Director, Oregon Health & Sciences University Center for Women's Health (former)

58. Berman, Rebecca, MD, FACP, Internal Medicine Residency Program Director, Associate Professor of Medicine, University of California, San Francisco

59. Bernard, Caitlin, MD, MSCI, Assistant Clinical Professor, Indiana University School of Medicine, Department of Obstetrics and Gynecology

60. Berry, Lisa, MS, Licensed Genetic Counselor, Cincinnati Children's Hospital Medical Center

61. Berwick, Donald M., MD, MPP., Lecturer, Department of Health Care Policy, Harvard Medical School

62. Berz, Jonathan, MD, Assistant Professor of Medicine, Boston University School of Medicine

63. Bhagat, Santi KM, MD, MPH, Founder and President, Physician-Parent Caregivers, The Invisible Wave

64. Bhattacharya, Gauri, PhD/DSW, MSW, MA, LCSW, ACSW, Former Interim Associate Dean and Full Professor, School of School Work, Jackson State University

65. Bishop, Laura, MD, FAAP, FACP, Associate Professor, Departments of Internal Medicine & Pediatrics, University of Louisville

66. Blakemore, Karin J., MD, Professor, Gynecology and Obstetrics, Director, Prenatal Diagnostic Center, Johns Hopkins University School of Medicine

67. Blanchard, Janice, MD, PhD, Professor, Chief, Health Policy Section, Department of Emergency Medicine, The George Washington University

68. Blatt, Benjamin, MD, CHSE, Professor of Medicine, The George Washington University School of Medicine

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

70. Blum, Robert Wm., MD, MPH, PhD, Principal Investigator, Global Early Adolescent Study, Professor, Department of Population, Family and Reproductive Health, John Hopkins Bloomberg School of Public Health

71. Bonnema, Rachel, MD, MS, FACP., Professor of Medicine, University of Texas Southwestern

72. Boozer, Margaret, MD, MPH, Associate Professor, Director of Family Planning, Department of OB/GYN, University of Alabama at Birmingham

73. Boraas, Christy, MD, MPH, FACOG, Associate Professor, Department of

OB/GYN/Women's Health, University of Minnesota Medical School

74. Boris, Eileen, PhD, MA, Hull Professor and Distinguished Professor of Feminist Studies, Distinguished Professor of History, Black Studies, and Global Studies, University of California, Santa Barbara

75. Borkowski, Liz, MPH, Senior Research Scientist, Managing Director, Jacobs Institute of Women's Health, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

76. Borzecki, Ann, MD, Research Associate Professor, Department of Health Law, Policy & Management, Boston University School of Public Health

77. Bowie, Janice, PhD, MPH, Bloomberg Centennial Professor, Chair, Schoolwide DrPH Program, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health

78. Braaten, Kari P., MD, MPH, Assistant Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School

79. Brantley, Erin, PhD, MPH, Public Health Researcher

80. Brown, Benjamin Patterson, MD, MS, Mimi Pichey Assistant Professor of Obstetrics and Gynecology, Chief, Section of Complex Family Planning, Division of General Obstetrics and Gynecology, Alpert Medical School of Brown University

81. Browner, Carole H., PhD, MPH, Distinguished Research Professor, Center for Culture and Health, Semel Institute for Neuroscience and Human Behavior, Department of Anthropology, Department of Gender Studies, University of California, Los Angeles

82. Brysk, Alison, PhD, Chair, Global Studies Department, Mellichamp Professor of Global Governance, University of California, Santa Barbara

83. Bulun, Serdar, MD, John J. Sciarra Professor, Chair, Department of Obstetrics and Gynecology, Feinberg School of Medicine at Northwestern University

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

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

86. Callender, Ealena, MD, FACOG, OB/GYN, Milken Institute School of Public Health, The George Washington University

87. Carey, Katheen, PhD, Professor, Department of Health Law, Policy and Management, Boston University School of Public Health

88. Casoni, Maria, MPH, MSL, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

89. Cassady, Diana, DrPH, Professor, Public Health Sciences Department, Chair, Graduate Group in Public Health Sciences, University of California, Davis

90. Castaño, Paula, MD, MPH, Associate Professor in OB/GYN, Columbia University

91. 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

92. Celentano, David D., ScD, MHS, Dr. Charles Armstrong Chair in Epidemiology, Professor and Chair, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health

93. Cerminara, Kathy L., JD, JSD, LLM, Professor of Law, Shepard Broad College of Law, NSU Florida

94. Campion, MaryAnn W., EdD, MS, CGC, Professor, Licensed, Certified Genetic Counselor, Co-Director, MS Program in Human Genetics & Genetic Counseling, Department of Genetics, Stanford University School of Medicine

95. Chang, Aileen, MD, MSPH, Associate Professor of Medicine, The George Washington University School of Medicine and Health Sciences

96. Charlton, Brittany M., ScD, Assistant Professor, Harvard Medical School and Harvard T.H. Chan School of Public Health

97. 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

98. Chawla, Reeti, MD, Attending Physician, Division of Pediatric Endocrinology, Phoenix Children's Hospital

99. Chen, Angela Y., MD, MPH, FACOG, Family Planning Chief of Service & Fellowship Director, Associate Professor of Obstetrics & Gynecology, David Geffen School of Medicine, University of California, Los Angeles

100. Chernoby, Kimberly, MD, JD, Clinical Instructor of Emergency Medicine, The George

Washington University School of Medicine and Health Sciences

101. Chin, Jennifer, MD, Assistant Professor in Obstetrics and Gynecology and Complex Family Planning, University of Washington

102. Christian, Parul, DrPH, MSc, Professor, Director and Associate Chair, Department of International Health, Johns Hopkins Bloomberg School of Public Health

103. Chuang, Emmeline, PhD, Associate Professor of Health Policy and Management, University of California, Los Angeles Fielding School of Public Health

104. Clark, Jack A., PhD, Professor, Health Law, Policy and Management, Boston University School of Public Health

105. Cochran, Susan D., PhD, MS, Professor of Epidemiology and Statistics, Fielding School of Public Health, University of California, Los Angeles

106. 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

107. Cohen, Jessica, PhD, Professor of Health Economics, Harvard T.H. Chan School of Public Health

108. Cole, Megan B., PhD, MPH, Associate Professor, Department of Health Law, Policy, and Management, Co-Director, BU Medicaid Policy Lab, Boston University School of Public Health

109. Costich, Julia F., JD, PhD, Peter P. Bosomworth Professor of Health Services Research, Department of Health Management and Policy, Associate Director, Ky. Injury Prevention and Research Center, UK College of Public Health

110. Courtney, Kristine B., MS, CGC, Certified Genetic Counselor, MFM Consultants of Dallas

111. Creinin, Mitchell, MD, Distinguished Professor, Director, Complex Family Planning Fellowship, Department of Obstetrics and Gynecology, University of California, Davis

112. Crossley, Mary, JD, Professor of Law, University of Pittsburgh School of Law

113. Cuca, Yvette, PhD, MPH, MIA, Specialist, Community Health Systems, School of Nursing, University of California, San Francisco

114. Cuello, Leonardo, JD, Research Professor, Center for Children and Families, Georgetown University McCourt School of Public Policy

115. Culwell, Kelly, MD, MPH, Chief Medical Officer and Head of Research and Development, Sebela Women's Health; Associate Clinical Professor, University of California, San Diego

116. Cwiak, Carrie, MD, MPH, Chief, Obstetrics and Gynecology, Emory University Hospital Midtown, Director, Complex Family Planning Fellowship, Department of Gynecology and Obstetrics, Emory University School of Medicine

117. Daniel, Clare, PhD, Senior Professor of Practice and Director of Research, Newcomb Institute of Tulane University

118. Darney, Philip, MD, MSc, Distinguished Professor, Emeritus, Department of Obstetrics, Gynecology, Reproductive Sciences and Health Policy, Director, Bixby Center for Global Reproductive Health, University of California, San Francisco

119. Deardorff, Julianna, PhD, Professor, Community Health Sciences Division, School of Public Health, University of California Berkeley

120. Deeb-Sossa, Natalia, Professor, Chicana/o/x Studies, University of California, Davis

121. Dehlendorf, Christine, MD, MAS, Professor, Vice Chair for Research, Family & Community Medicine, Director, Person-Centered Reproductive Health Program, Department of Family & Community Medicine, Obstetrics, Gynecology & Reproductive Sciences, and Epidemiology & Biostatistics, University of California, San Francisco

122. Delgado, Ana, CNM, MS, UCSF Department of OB/GYN, University of California, San Francisco

123. Denbow, Jennifer, JD, MPH, Assistant Professor of Political Science, California Polytechnic State University, San Luis Obispo

124. Dethier, Divya, MD, Complex Family Planning Fellow, University of Hawaii

125. Dineen Gillespie, Kelly K., JD, PhD, Professor, Center for Health Law Studies, School of Law, Saint Louis University

126. Dirrigl, Karen, MS, Genetic Counselor, Dignity Health Center Institute at St. Joseph's Hospital and Medical Center

127. Doan, Alesha, PhD, Professor, School of Public Affairs & Administration, Professor, Department of Women, Gender & Sexuality Studies, University of Kansas

128. Doge, Laura E., ScD, MPH, Director of the Division of Research, Assistant Professor, Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Harvard Medical School Teaching Hospital

129. Donahue, Amy, MLIS, MGCS, CGC, Certified Genetic Counselor, Associate Professor, MS in Genetic Counseling Program, Froedtert & the Medical College of Wisconsin

130. Donelan, Karen, ScD, Stuart H. Altman Professor of US Health Policy, Heller School of Social Policy & Management, Brandeis University

131. Donley, Greer, JD, Assistant Professor of Law, University of Pittsburgh Law School

132. Douglas, Jessica K., LMSW Associate in the Practice of C.L. Bockwitz, LPC

133. Dragoman, Monica, MD, MPH, Program Director, Complex Family Planning Fellowship, Department of Obstetrics, Gynecology, and Reproductive Science, Icahn School of Medicine at Mount Sinai

134. Drey, Eleanor, MD, EdM, Acting Chief, ZSFG OB-GYN Division, Medical Director, Z.S.F.G. Women's Options Center, Professor, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco

135. Dupras, Denise M., MD, PhD, Associate Professor of Medicine, Consultant, Primary Care Internal Medicine, Alix School of Medicine, Mayo Clinic

136. Durbin, Anna, MD, Professor, International Health, Johns Hopkins Bloomberg School of Public Health

137. Dutton, Caryn, MD, Medical Director, Gynecology Practice, Brigham and Women's Hospital

138. Easter, Sarah Rae MD, Director of Obstetric Critical Care, Division of Maternal-Fetal Medicine, Division of Critical Care Medicine, Brigham and Women's Hospital, Assistant Professor, Harvard Medical School

139. Ecker, Jeffrey L., MD, Joe V. Meigs Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Chief, Obstetrics and Gynecology, Massachusetts General Hospital

140. Eckhardt, Cara L., PhD, MPH, Professor, OHSU-PSU School of Public Health

141. Economou, Nicole, MD, MPH, Assistant Clinical Professor, UC Davis Health

142. Edelman, Alison, MD, MPH, Professor, OB/GYN, Director, Oregon Fellowship in Complex Family Planning, Director, Section of

Family Planning, Oregon Health & Science University

143. Ehrlich, Shoshanna, JD, Professor Emerita, Women's, Gender, and Sexuality Studies, UMass Boston

144. Eisenberg, David L., MD, MPH, FACOG, Professor, Division of Complex Family Planning, Department of Obstetrics & Gynecology, Washington University in St. Louis School of Medicine

145. El Ayadi, Alison M. ScD, MPH, Associate Professor, Department of Obstetrics, Gynecology and Reproductive Sciences, Department of Epidemiology and Biostatistics, University of California, San Francisco

146. Eliason, Erica, PhD, Postdoctoral Research Fellow, Brown University School of Public Health

147. Ellison, Olivia, MPH, CHES, Rutgers University, Health Program Analyst, Los Angeles County, Department of Public Health

148. Engle, Jill C., Professor of Clinical Law, Penn State Dickinson Law

149. Erikson, Clese, MPAff, Deputy Director, Health Workforce Research Center, Fitzhugh Mullan Institute for Health Workforce Equity, Department of Health Policy and Management,

Milken Institute School of Public Health, The George Washington University

150. Espey, Eve MD, MPH, Distinguished Professor, Department of OB-GYN, University of New Mexico

151. 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

152. Farris, Katherine, MD, Chief Medical Officer, Planned Parenthood South Atlantic

153. Fentiman, Linda C., JD, LLM, Professor Emerita, Elisabeth Haub School of Law, Pace University

154. Fershee, Kendra, JD, Professor, Creighton University School of Law

155. 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

156. Fleisher, Jonah, MD, MPH, FACOG, Associate Professor, Clinical Obstetrics and Gynecology, Director, Center for Reproductive Health, University of Illinois at Chicago

157. Ford, Chandra L., PhD, MPH, MLIS, Associate Professor, Department of Community Health Sciences, Founding Director, Center for the Study of Racism, Social Justice & Health, Jonathan & Karin Fielding School of Public Health, University of California, Los Angeles

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

159. Francis, Leslie, JD, PhD, Distinguished Alfred C. Emery Professor of Law, Distinguished Professor of Philosophy, University of Utah

160. Frank, Sally, JD, MA, Professor of Law, Drake University

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

162. Fredrick, Beth, Senior Associate, Population, Family and Reproductive Health Department, Johns Hopkins Bloomberg School of Public Health

163. Freedman, Lynn P., JD, MPH., Professor of Population and Family Health at CUIMC, Director, Averting Maternal Death and Disability Program, Columbia University Mailman School of Public Health

164. Fried, Ethan D., MD, MACP, Associate Chair for Education, Residency Program Director, Department of Internal Medicine, Professor of

Medicine, Zucker School of Medicine at Hofstra/Northwell

165. Frisse, Ann, MD, Complex Family Planning Fellow, Department of Obstetrics, Gynecology, and Reproductive Science, Mount Sinai

166. Frogner, Bianca K., PhD, Professor, Department of Family Medicine, Director, Center for Health Workforce Studies, School of Medicine, University of Washington

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

168. Ganguli, Ishani, MD, MPH, Assistant Professor of Medicine, Harvard Medical School

169. Garcia, Lorena, MPH, DrPH, Professor, Director, Undergraduate Education, Department of Public Health Sciences, Division of Epidemiology, UC Davis School of Medicine

170. Gazelle, Gail, MD, Assistant Professor of Medicine, Harvard Medical School

171. Geddes, Christina, Research Assistant, Guttmacher Institute

172. Geller, Stacie, PhD, G William Arends Professor of Obstetrics and Gynecology, Professor, Division of Academic Internal Medicine, Department of Medicine, Director, Center for Research on Women and Gender,

College of Medicine, University of Illinois, Chicago

173. Gelmon, Sherril B., DrPH, Professor Emerita of Health Systems Management and Policy, Oregon Health & Science University – Portland State University School of Public Health, Portland State University

174. Geltman, Elizabeth, JD, LLM, Associate Professor, Department of Health Policy and Management, CUNY Graduate School of Public Health and Health Policy, Lecturer, Johns Hopkins University, Chair, APHA Law Section

175. Gemmill, Alison, PhD, MPH, Assistant Professor, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

176. Ghorashi, Adrienne R., JD, Program Manager, Center for Public Health Law Research, Temple University, Beasley School of Law

177. Ghosh, S. Monty, BSc., MBT, MSc., MD, FRCPC, DM-EMDM ISAM(C) CSAM, Internal Medicine, Disaster Medicine, and Addiction Medicine, Assistant Professor, Departments of General Internal Medicine and Neurology, The University of Alberta, Clinical Assistant Professor, Departments of Medicine and Psychiatry, The University of Calgary

178. Gillespie, Duff, PhD, Professor, Bill & Melinda Gates Institute for Population and

Reproductive Health, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

179. Gipson, Jessica D., MPH, PhD, Professor and Fred H. Bixby Endowed Chair on Population and Reproductive Health, Director, UCLA Bixby Center to Advance Sexual and Reproductive Health Equity, Department of Community Health Sciences, University of California, Los Angeles Fielding School of Public Health

180. Glantz, Leonard H., JD, Emeritus Professor, Health Law, Policy and Management, Boston University School of Public Health

181. Godfrey, Emily M., MD, MPH, FAAFP., Associate Professor, Department of Family Medicine, Research Section, Department of Obstetrics and Gynecology, Division of Family Planning, University of Washington

182. Godley, Sophie, DrPH, Clinical Assistant Professor, Boston University School of Public Health

183. Godzich, Micaela, MD, Associate Clinical Professor, Department of Family and Community Medicine, UC Davis School of Medicine

184. Goff, Barbara, MD, Chair, Obstetrics and Gynecology, University of Washington,

Surgeon-in-Chief, University of Washington Medical Center

185. Goldberg, Alisa B., MD, MPH, Associate Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School; Director, Division of Family Planning, Brigham and Women's Hospital

186. Goldberg, Daniel S., JD, PhD, Core Faculty, Center for Bioethics and Humanities, Associate Professor, Department of Family Medicine, Associate Professor, Department of Epidemiology, University of Colorado Anschutz Medical Campus

187. Goldberg, Randy, MD, MPH, FACP, FHM, Assistant Professor of Clinical Medicine, New York Medical College; Hospitalist and Chair of Clinical Ethics, Westchester Medical Center

188. Goldin Evans, Melissa, PhD, MsPH, Assistant Professor, Mary Amelia Center for Women's Health Equity Research (MAC), Tulane University Celia Scott Weatherhead School of Public Health & Tropical Medicine

189. Goldman, Noreen J., DSc, MSc, MA, Hughes-Rogers Professor of Demography and Public Affairs, Princeton University

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

191. Goldthwaite, Lisa M., MD, MPH, Clinical Assistant Professor of Obstetrics and Gynecology, Stanford University School of Medicine

192. Goodwin, Alexandra M., MD, Clinical Assistant Professor, N.Y.U. Department of General Internal Medicine/Bellevue Hospital

193. Goold, Susan Dorr, MD, MHSA, MA, FACP, Professor of Internal Medicine, School of Medicine, Professor of Health Management and Policy, School of Public Health, University of Michigan

194. Gorbach, Pamina M., MHS, DrPH, Professor, Department of Epidemiology, Fielding School of Public Health, Division of Infectious Diseases, David Geffen School of Medicine, University of California, Los Angeles

195. Gordon, Sara H., PhD, MS, Assistant Professor, Health Law, Policy, and Management, Co-Director, BU Medicaid Policy Lab, Boston University School of Public Health

196. Gostin, Lawrence O., JD, LLD, University Professor, Founding O'Neill Chair in Global Health Law, Faculty Director, O'Neill Institute for National and Global Health Law, Director, World Health Organization Collaborating Center on National & Global Health Law, Georgetown Law School

197. Graham, Misasha S., JD, Solo Practitioner

198. Gray, Kathryn J., MD, PhD, Attending Physician, Maternal-Fetal Medicine, Brigham and Women's Hospital

199. Gupta, Pratima, MD, MPH, Assistant Staff Physician, University of San Diego School of Medicine

200. Guyer, Bernard, MD, MPH, Zanvyl Krieger Professor of Children's Health, Emeritus, Johns Hopkins Bloomberg School of Public Health

201. Hackman, Christine L., PhD, MCHES, Associate Professor, Kinesiology & Public Health, California Polytechnic State University

202. Hagey, Jill, MD, MPH, Complex Family Planning Fellow, Department of Obstetrics and Gynecology, University of Chapel Hill, North Carolina

203. Hammond, Cassing, MD, Director, Section and Fellowship in Complex Family Planning, Associate Professor of Obstetrics and Gynecology, Northwestern Feinberg School of Medicine

204. Handler, Arden, DrPH, Professor Emeritus, Community Health Sciences, University of Illinois School of Public Health

205. Hardeman, Rachel R., PhD, MPH, Blue Cross Endowed Professor of Health and Racial Equity, Founding Director, Center for Antiracism Research for Health Equity, Division of Health Policy & Management, University of Minnesota School of Public Health

206. Hardy, Melanie, MS, MS, CGC, Licensed, Certified Genetic Counselor, Director of Research and Advocacy, jscreen.org

207. Harken, Tabetha R., MD, MPH, Professor of Obstetrics & Gynecology, Division Director of Family Planning, University of California, Irvine

208. Harper, Cynthia C., PhD, Professor and Interim Vice Chair for Research, Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco

209. Harrington, Amy R., MD, Associate Professor, Obstetrics & Gynecology, URMC Family Planning, Residency Program Director, Obstetrics & Gynecology, University of Rochester Medical Center

210. Hathaway, Mark, MD, MPH, Medical Director - Carafem, Sr. Technical Advisor for Reproductive Health and Family Planning-Jhpiego, Adjunct Assistant Professor in Gynecology and Obstetrics, Johns Hopkins University

211. Hazel, Elizabeth, PhD, Assistant Research Professor, International Health Department, Johns Hopkins Bloomberg School of Public Health

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

213. Heise, Lori, PhD, Professor, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

214. Heled, Yaniv, JSD, Professor of Law, Co-Director, Center for Intellectual Property, Center for Law, Health & Society, Georgia State University College of Law

215. Henderson, Jillian T., PhD, MPH, Investigator, Kaiser Permanente, Northwest, Center for Health Research, KP Evidence-based Practice Center

216. Hennessey, Catherine, MD, Family Planning Fellow, University of Chicago

217. 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

218. Hercher, Laura, MS, CGC, Director of Student Research, Sarah Lawrence College Joan H. Marks Graduate Program in Human Genetics

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

220. Herold, Stephanie, MPH, Data Analyst, Advancing New Standards in Reproductive Health, University of California, San Francisco

221. Hersh, Alyssa R., MD, MPH, Resident Physician, Department of Obstetrics & Gynecology, Oregon Health & Science University

222. Higgins, Stacy, MD, Professor of Medicine, Emory University School of Medicine

223. Hillard, Paula J. Adams, MD, Professor, Department of Obstetrics and Gynecology, Stanford University School of Medicine

224. Ho, Vivian, PhD, Director, Center for Health and Biosciences, Baker Institute, Professor, Department of Economics, Professor, Baylor College of Medicine, Rice University Department of Economics

225. Region Office – Network for Public Health Law, Sandra Day O'Connor College of Law

226. Hoefling, Tricia A., JD, Adjunct Professor, Georgetown Law

227. 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

228. Hoffmann, Diane E., JD, Jacob A. France Professor of Health Law, Director, Law & Health Care Program, University of Maryland Carey School of Law

229. Holman, E. Alison, PhD, F.N.P., Associate Professor, Sue & Bill Gross School of Nursing, University of California, Irvine

230. Holt, Kelsey, ScD, MA, Assistant Professor, Department of Family & Community Medicine, School of Medicine, University of California, San Francisco

231. 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

232. Huberfeld, Nicole, Edward R. Utley Professor of Health Law, Co-Director, BU Program on Reproductive Justice, Chair, BU Health Law Program, Boston University School of Law and School of Public Health

233. Hutchison, Margy, CNM, Clinical Professor, Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco

234. Ikemoto, Lisa C., JD, LLM, Martin Luther King, Jr. Professor of Law, University of California, Davis School of Law

235. Imershein, Sara, MD, MPH, FACOG, Clinical Professor OB-GYN, The George Washington University School of Medicine and Health Sciences

236. Ireland, Luu, MD, MPH, FACOG, Assistant Professor of Obstetrics and Gynecology, OB/GYN Director of Diversity, Equity and Inclusion, MA-ACOG Legislative Chair, UMass Memorial Medical Center

237. Jacobs, Adam, MD, Medical Director, Division of Family Planning Mount Sinai Health System, Medical Director Family Planning, Bronxcare Medical Center, Associate Professor, OB/GYN, Pediatrics, and Medical Education, Icahn School of Medicine, Mount Sinai

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

239. Jacobson, David, MD, FACP, Program Director, Internal Medicine Residency, Santa Clara Valley Medical Center, Clinical Associate Professor (Affiliated), Stanford University School of Medicine, Clinical Associate Professor of Medicine, Geisel School of Medicine

240. Jayaweera, Ruvani, PhD, MPH, Senior Associate Research Scientist, Ibis Reproductive Health

241. Joffe, Carole, PhD, Professor Emerita of Sociology, University of California, Davis, Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco

242. 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

243. Johnson, Dana M., MPAff, PhD, University of Wisconsin-Madison School of Medicine and Public Health

244. Jones, Heidi E., PhD, MPH, Director, Doctoral Program in Epidemiology, Professor, Department of Epidemiology & Biostatistics, CUNY Graduate School of Public Health and Health Policy

245. Kahn, Chava, MD, MPH, Interim Director of Surgical Services, Planned Parenthood of Maryland

246. Kahn, James G., MD, MPH, Professor of Health Policy, Epidemiology, and Global Health, Phillip R. Lee Institute for Health Policy

Studies, University of California, San Francisco

247. Kalsy, Sapna, MD, MPH, Physician, Planned Parenthood Southwest Ohio; Physicians for Reproductive Health Fellow

248. Kamali, Deborah, MD, Associate Professor, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco Women's Health

249. Kaneshiro, Bliss, MD, MPH, Professor, University of Hawaii Johns A. Burns School of Medicine

250. Kapadia, Farzana, PhD, MPH, Professor of Epidemiology, Deputy Editor, AJPH, New York University School of Global Public Health

251. Kaplan, Sherrie H., PhD, MPH, Professor of Medicine and Anesthesiology & Perioperative Care, Assistant Vice Chancellor, Healthcare, Evaluation and Measurement, University of California Irvine School of Medicine

252. Karlan, Beth Y., MD, Vice Chair, Women's Health Research, Professor, Department of Obstetrics and Gynecology, Director, Cancer Population Genetics, Jonsson Comprehensive Cancer Center, David Geffen School of Medicine, University of California, Los Angeles

253. Karron, Ruth A., MD, Professor, International Health, Director, Center for Immunization

Research, Director, Johns Hopkins Vaccine Initiative, Johns Hopkins Bloomberg School of Public Health

254. Katz, Ingrid, MD, MHS., Assistant Professor of Medicine, Harvard Medical School

255. Katz, Joanne, ScD, Professor, Global Disease Epidemiology and Control Program, Department of International Health, Johns Hopkins Bloomberg School of Public Health

256. Katzburg, Judith R., PhD, MPH, RN, Health Services Researcher, Past Chair, Maternal & Child Health Section, American Public Health Association

257. Kayser, Georgia, PhD, Assistant Professor, Division of Global Health, Family Medicine and Public Health, The School of Medicine, University of California, San Diego

258. Keating, Nancy L., MD, MPH, Professor of Health Care Policy and Medicine, Harvard Medical School

259. Kennedy, Caitlin, MPH, PhD, Professor, Director, Social and Behavioral Interventions Program, Associate Chair, Department of International Health, Johns Hopkins Bloomberg School of Public Health

260. Kenney, Sally J., PhD, Newcomb College Endowed Chair, Executive Director, Newcomb

Institute, Professor of Political Science, Tulane University

261. Kersey, Lynn, MA, MPH., CLE, Executive Director, Maternal and Child Health Access

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

263. Kibby, Thomas, MD, MPH, Program Director, Preventive Medicine Residency, Washington University School of Medicine

264. Kirstein, Marielle R., Senior Research Assistant, Guttmacher Institute

265. Kissinger, Patricia, PhD, MPH, BSN, Professor of Epidemiology, Tulane University School of Public Health and Tropical Medicine

266. Knoll, Maria Deloria, PhD, Senior Scientist, Director, Epidemiology, International Vaccine Access Center, Department of International Health, Johns Hopkins Bloomberg School of Public Health

267. Ko, Jennifer, Project Director, Advancing New Standards in Reproductive Health, Bixby Center for Global Reproductive Health, University of California, San Francisco

268. Koch, Jennifer, MD, FACP, Professor of Medicine, Program Director, Internal Medicine Residency, University of Louisville

269. Kottke, Melissa, MD, MPH, MBA, Associate Professor, Department of Gynecology and Obstetrics, Emory University School of Medicine

270. Kroker-Bode, Claudia, MD, PhD, FACP, Director, Internal Medicine Residency Florida State University, Professor, Clinical Sciences Florida State University College of Medicine

271. Kuhn, Randall, PhD, MA, Associate Professor, Department of Community Health Sciences, University of California, Los Angeles Fielding School of Public Health

272. LaCroix, Andrea Z., PhD, Professor and Chief of Epidemiology, Director, Women's Health Center of Excellence, Family Medicine and Public Health, University of California, San Diego

273. Lancaster, Emily, MS, CGC, Licensed Certified Counselor, Division of Genetic and Genomic Medicine, UPMC Children's Hospital of Pittsburgh

274. 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

275. Landes, Scott D., PhD, Associate Professor of Sociology, Syracuse University

276. Landon, Bruce E., MD, MBA, MSc, Professor of Health Care Policy, Harvard Medical School, Professor of Medicine, Beth Israel Deaconess Medical Center

277. Landy, Uta, PhD, Senior Advisor, University of California, San Francisco, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology, and Reproductive Sciences

278. Lang, Valerie J., MD, MHPE, Professor of Medicine,
Associate Chair for Medical Education Research and Scholarship, Department of Medicine; Senior Associate Division Chief, Hospital Medicine Division; Rochester University School of Medicine & Dentistry

279. Langer, Ana, Professor of the Practice of Public Health, Coordinator of the Dean's Special Initiative on Women and Health, Department of Global Health and Population, Harvard T.H. Chan School of Public Health

280. 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

281. LaPuma, Peter, PhD, CIH, PE, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University

282. Lasser, Karen E., MD, MPH, Professor of Medicine, Boston Medical Center, Boston University School of Medicine

283. Lee, Kacia, MD, Adjunct Professor of Medicine, University of Minnesota Medical School

284. Leibowitz, Arleen A., PhD, Professor Emeritus and Research Professor, UCLA Luskin School of Public Affairs

285. Leonard, Katie, FNP-BC, Nurse Practitioner, Adolescent Medicine, BC4U Family Planning, University of Colorado School of Medicine

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

287. Levy, Adam, MD, Associate Professor, OB/GYN, Ryan Program Director, UNLV School of Medicine

288. Lewin, Amy B., PsyD, Associate Professor, Family Science, University of Maryland School of Public Health

289. Lewis-O'Connor, Annie, PhD, NP, MPH, Instructor in Medicine, Harvard Medical School, Founder and Director, C.A.R.E. Clinic-Brigham and Women's Hospital

290. Leyser-Whalen, Ophra, PhD, Associate Professor, Sociology and Anthropology, University of Texas at El Paso

291. Liberty, Abigail, MD, MSPH, Complex Family Planning Fellow, Department of Obstetrics & Gynecology, Oregon Health & Science University

292. Liddell, Jessica, PhD, MSW, MPH, Assistant Professor, School of Social Work, University of Montana

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

294. Loscalzo, Joseph, MD, PhD, Hersey Professor of the Theory and Practice of Medicine, Harvard Medical School, Chairman of the Department of Medicine and Physician-in-Chief, Brigham and Women's Hospital

295. Loza, Julie, MD, Assistant Professor of Clinical Family Medicine, Department of Family and Community Medicine, University of Illinois at Chicago

296. Lupton, Katherine, MD, FACP., Associate Professor of Medicine, University of California School of Medicine

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

298. Maloof-Bury, Paris, MSN, CNM, RNC-OB, IBCLC, President, California Nurse-Midwives Association

299. Mamo, Laura PhD, Director, Heath Equity Institute and Professor, Public Health, San Francisco State University

300. Manian, Maya, JD, Professor of Law, American University Washington College of Law

301. Mao, Constance, MD, Associate Professor Emeritus, Department of Obstetrics and Gynecology, University of Washington Harborview Medical Center

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

303. Mark, Nicholas, MA, Institute for Education Sciences – Predoctoral Interdisciplinary Training Fellow, New York University

304. 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

305. Martin, Lisa A., PhD, Department Chair, Health and Human Services, Professor of Women's and Gender Studies, Professor of Health and Human Services, University of Michigan, Dearborn

306. McCarthy, Melissa L., ScD, MS, Professor of Health Policy and Emergency Medicine, Milken Institute School of Public Health, The George Washington University

307. McCloskey, Lois, DrPH, MPH, Associate Professor, Director, Center of Excellence in Maternal and Child Health, Department of Community Health Sciences, Boston University School of Public Health

308. McConnell, K. John, PhD, Director, Center for Health Systems Effectiveness, Professor, Department of Emergency Medicine, Oregon Health & Science University

309. 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

310. McGhee, Julea Leshar, MD, MPH, Clinical Assistant Professor of Psychiatry &

Biobehavioral Sciences, David Geffen School of Medicine at UCLA

311. 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 Health Sciences, University of Rochester School of Medicine & Dentistry

312. Meckstroth, Karen, MD, MPH, Clinical Professor, Department of Obstetrics, Gynecology & Reproductive Sciences, Medical Director, UCSF Center for Pregnancy Options, University of California, San Francisco

313. Melnikow, Joy, MD, MPH, Professor, Department of Family and Community Medicine, Director, Center for Healthcare Policy and Research, University of California, Davis

314. Merkatz, Ruth B., PhD, RN, FAAN, Clinical Professor, Department of Obstetrics and Gynecology and Women's Health, Albert Einstein College of Medicine, Senior Clinical Scientist, Center for Biomedical Research, Population Council

315. Merriam, Sarah, MD, MS, Clinical Assistant Professor of Medicine, Division of General Internal Medicine, VA Pittsburgh Healthcare System

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

317. Mihaly, Lisa, FNP-BC, RN, Assistant Clinical Professor, Family Nurse Practitioner Program, Department of Family Health Care Nursing, School of Nursing, University of California, San Francisco

318. Miller, Velvet G., PhD, FAAN, Adjunct Assistant Professor Ret., Obstetrics and Gynecology Department, Indiana University School of Medicine

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

320. Mitchell, L. Kate, JD, Clinical Professor of Law, Director, Health Justice Project, Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law, Clinical Professor of Medicine, Department of Family Medicine, Loyola University Chicago Stritch School of Medicine

321. Montoya, Jim, MD, FACEP, FAAEM, Emergency Physician, Former Chief, Department of Emergency Medicine, Sutter Medical Center Sacramento

322. Moore, Michelle, MS, CGC, Senior Lab Genetic Counselor, Sanford Imagenetics

323. Moore Simas, Tiffany A., MD, MPH, MEd, FACOG, Chair, Department of Obstetrics & Gynecology, Pediatrics, Psychiatry and Population & Quantitative Health Sciences, University of Massachusetts Medical School/UMass Memorial Health

324. Moreau, Caroline, MD, PhD, Associate Professor, Population Family and Reproductive Health, Johns Hopkins School of Public Health

325. Morrell, Kathleen, MD, MPH, Director of Family Planning Division, Residency Program Director, Maimonides Medical Center, Department of Obstetrics & Gynecology

326. Muench, Ulrike, PhD, RN, FAAN, Assistant Professor, Co-director Health Policy Specialty, Department of Social & Behavioral Sciences, School of Nursing, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco

327. Murphy, Caitlin, MPA-PNP, Senior Research Associate, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

328. Musick, Jennifer, MPH, Professor, Health Education Department, Long Beach City College

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

330. Needleman, Jack, PhD, FAAN, Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health

331. Newmann, Sara, MD, MPH, Associate Professor, Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco

332. Nicholas, Lauren Hersch, PhD, MPP, Professor, Department of Medicine, University of Colorado

333. Nour, Nawal M., MD, MPH, Chair, Department of Obstetrics and Gynecology, Kate Macy Ladd Professorship, Harvard Medical School

334. Nwanodi, Oroma, MD, DHSc, FACOG, Science Board Member, APHA, Obstetric Hospitalist, OB Hospitalist Group

335. O'Connor, Alec B., MD, MPH, William Morgan Professor of Medicine, Director, Internal Medicine Residency Program, University of Rochester School of Medicine

336. Oaks, Laury, PhD, Professor, Department of Feminist Studies, University of California, Santa Barbara

337. Ogburn, Tony, MD, Professor and Chair, Department of Obstetrics and Gynecology, UTRGV School of Medicine

338. Olson, Iris Ryn, MPH, Center Manager, Center for Women's Health Research and Innovation, University of Pittsburgh

339. Ortiz, Damara, MD, FAAP, FACMGG, Assistant Professor of Pediatrics, Director, Lysosomal Storage Disorders Program, Program Director, Medical Genetics Residency, Medical Director, Genetic Counselor Training Program, Medical Genetics/PKU Department, UPMC Children's Hospital of Pittsburgh

340. Ozark, Laura, MD, FACP, Clinical Associate Professor, Associate Program Director, Internal Medicine Residency, Loyola University Medical Center

341. Pace, Lydia E.W., MD, MPH, Associate Physician, Division of Women's Health, Brigham and Women's Hospital, Interim Clinical and Research Director, Division of Women's Health, Brigham and Women's Hospital, Director of Women's Health Policy and Advocacy, Connors Center for Women's Health, Brigham and Women's Hospital, Associate Professor of Medicine, Harvard Medical School

342. Pargament, Robert, MD, FACP, General Internist, Internal Medicine Residency Program Director, WellSpan York Hospital

343. Park, Ina, MD, MS, Associate Professor, Department of Family and Community Medicine, University of California San Francisco School of Medicine

344. Parmet, Wendy E., JD, Matthews University Distinguished Professor of Law, Northeastern University

345. Patel, Ashlesha, MD, MPH, MsHQS, System Chair of Family Planning Services, Department of Obstetrics & Gynecology, Cook County Health, Professor, Department of Obstetrics & Gynecology, Feinberg School of Medicine, Northwestern University

346. Patil, Rajita, MD, FACOG, Assistant Clinical Professor, Department of Obstetrics and Gynecology, David Geffen School of Medicine, University of California, Los Angeles

347. Paulen, Melissa E., MD, MPH, Staff Physician, Planned Parenthood Great Northwest, Hawaii, Alaska, Indiana, Kentucky

348. Pebley, Anne R., PhD, Distinguished Professor and Fred H. Bixby Chair, Chair, Bixby Center on Popu- lation and Reproductive Health, UCLA Fielding School of Public Health

349. Peipert, Jeffrey F., MD, PhD, Clarence E. Ehrlich Professor and Chair, Department of Obstetrics & Gynecology, Indiana University School of Medicine

350. Peprah, Sayida, PsyD, Licensed Clinical Psychologist and Maternal Mental Health Consultant, Rancho Cucamonga, California

351. Perrin, James M., MD, Professor of Pediatrics Emeritus, Harvard Medical School, John C. Robinson Distinguished Chair in Pediatrics, MassGeneral for Children

352. Perry, Rachel, MD, MPH, Associate Professor of Obstetrics and Gynecology, University of California, Irvine

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

354. Pitney, Christie, CNM, WHNP, Forward Midwifery, Nursing, and Reproductive Health

355. 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

356. Pomeranz, Jennifer L., JD, MPH, Associate Professor, Department of Public Health Policy and Management, School of Global Health, New York University

357. Ponce, Ninez A., PhD, PhD, Director, UCLA Center for Health Policy Research, Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health

358. Prager, Sarah, MD, MAS, Professor of Obstetrics and Gynecology and Complex Family Planning, Complex Family Planning Division Chief, University of Washington

359. Prata, Ndola, MD, MSc, Fred H. Bixby Endowed Chair in Population and Family Planning, Professor, Maternal and Child Health, Director, Innovations for Youth, School of Public Health, Director, Center of Expertise in Women's Health, Gender and Empowerment, Global Health Institute, University of California, Berkley

360. Pressman, Eva K., MD, Henry A. Thiede Professor and Chair, Obstetrics and Gynecology, University of Rochester

361. Prine, Linda, MD, FAAFP, Professor of Family and Community Medicine, Mt. Sinai School of Medicine

362. Quinn, Gwendolyn P., PhD, MS, Livia Wan Endowed Chair, Vice-Chair, Research Professor, Department of OB-GYN, Department of Population Health, Division of Medical Ethics, New York University, School of Medicine

363. Rachel, Sharon A., MA, MPH, MS, Principal Faculty, Department of Physician Assistant Studies, Morehouse School of Medicine

364. Raj, Anita, PhD, Executive Director, Newcomb Institute, Nancy Reeves Dreux Chair and Professor, Celia Weatherhead School of Public Health and Tropical Medicine, Tulane University

365. Ramaiya, Astha, DrPH, Assistant Scientist, Gender Equity Unit, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health

366. Reed, Elizabeth, ScD, MPH, Associate Professor of Global Health, Co-Director, SDSU-UCSD Global Health Joint Doctoral Program, Division of Health Promotion and Behavioral Science, Graduate School of Public Health, San Diego State University

367. Reeves, Matthew, MD, MPH, FACOG, Chief Executive Officer, DuPont Clinic; Clinical Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine and Health Sciences; Adjunct Clinical Associate Professor of Obstetrics and Gynecology, Stanford University School of Medicine; Adjunct Associate Professor of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

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

369. Reich, Jennifer, PhD, Professor, University of Colorado Denver

370. Reid, Jessica, MD, MCR, Assistant Professor, Oregon Health & Sciences University

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

372. Rexrode, Kathryn M., MD, MPH, Chief, Division of Women's Health, Brigham and Women's Hospital

373. Rice, Laurel W., MD, Co-Chair, Women First Research Coalition

374. Rice, Thomas, PhD, Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health

375. Rich-Edwards, Janet, ScD, MPH, Associate Professor of Medicine, Harvard Medical School, Associate Professor in Epidemiology, Harvard T.H. Chan School of Public Health

376. Richards, Adam K., MD, PhD, MPH, DTM&H, Associate Professor, Department of Global Health, Milken Institute School of Public Health, Department of Medicine, School of

Medicine and Health Science, The George Washington University

377. Ricketts, Thomas C., PhD, MPH, Senior Policy Fellow, Cecil G. Sheps Center for Health Services Research, Professor of Health Policy and Management and Social Medicine, The University of North Carolina at Chapel Hill

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

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

380. Rittenberg, Eve, MD, Assistant Professor of Medicine, Harvard Medical School

381. Rodriguez, Maria I., MD, MPH, Associate Professor, Obstetrics & Gynecology, Center for Health Systems Effectiveness, Oregon Health & Science University

382. Rogow, Deborah, MPH, Reproductive Health Policy Analyst, Independent Consultant

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

384. Rosen, Joanne, JD, MA, Practice Professor, Director, Center for Law and the Public's Health, Johns Hopkins Bloomberg School of Public Health

385. Rosenbaum, Ellen, MPH, Data Coordinator, Sexual and Reproductive Health Services, Health Imperatives

386. 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

387. Rosenbloom, David, PhD, Professor of Public Health, Boston University School of Public Health

388. Rossi-Foulkes, Rita, MD, FAAP, MS, FACP, Program Director, University of Chicago Internal Medicine-Pediatrics Residency, Associate Professor of Internal Medicine and Pediatrics, University of Chicago Medicine

389. Roy, Brita, MD, MPH, MHS, Assistant Professor of Medicine, Director of Population Health, Yale University School of Medicine

390. Runyan, Aliye, MD, OBGYN, Westchester Medical Center, New York

391. Russo, Jennefer, MD, MPH, Vice Chair of Clinical Affairs, Department of OBGYN,

Harbor-UCLA Medical Center, Associate Clinical Professor, UCLA

392. Sacks, Tina K., PhD, Assistant Professor, School of Social Welfare, University of California at Berkeley

393. Safi, Sally, PhD, MSPH, Senior Technical Advisor for Capacity Building, PMA-Ethiopia, Bill and Melinda Gates Institute for Population and Reproductive Health, Department of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public

394. Sagaser, Katelynn G., MS, CGC, Assistant Professor, Department of Gynecology and Obstetrics, Johns Hopkins University School of Medicine, Certified Genetic Counselor, Johns Hopkins Hospital, Prenatal Diagnosis & Treatment Center

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

396. Salmeron, Carolina, MPH, Senior Project Director, Texas Campaign to Prevent Teen Pregnancy

397. Sankaran, Gopal, MD, DrPH, MNAMS, CHES, Professor of Public Health, Department of Health, College of Health Sciences, West Chester University

398. Sankey, Heather Z., MD, MEd, FACOG, CPE, Ronald T. Burkman Endowed Chair of Obstetrics and Gynecology, Baystate Health, Professor and Chair, University of Massachusetts Medical School-Baystate

399. 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

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

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

402. Schroeder, Elizabeth, M.P.H., Program Officer, Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health

403. Sebastian, Jessica, MS, CGC, Certified and Licensed Genetic Counselor, III, UPMC Children's Hospital of Pittsburgh

404. Seidman, Dominika, MD, MA, Assistant Professor, Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco

405. Serapio, Elissa, MD, MPH, Clinical Fellow, University of California, San Francisco School of Medicine

406. Shafer, Paul, PhD, Assistant Professor, Department of Health Law, Policy, and Management, Boston University School of Public Health

407. Shakya, Holly, PhD, Assistant Professor, Department of Medicine, Division Global Public Health, University of California, San Diego

408. Shapiro, Lauren, MD, Program Director Internal Medicine Residency Program, Associate Professor of Medicine, Montefiore Medical Center, The University Hospital for Albert Einstein College of Medicine

409. Shapiro, Marit Pearlman, MD, MPH, Complex Family Planning Fellow, University of Hawai'i

410. Shoptaw, Steven, PhD, Professor and Vice Chair for Research, Department of Family Medicine, David Geffen School of Medicine, University of California, Los Angeles

411. Sibley, Jessica, PhD, JD, Professor of Law and Yanakakis Faculty Research Scholar, Boston University School of Law

412. Sider, Darby, MD, MEHPE, FACP, FAAP, Internal Medicine Program Director, Cleveland Clinic Florida

413. 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

414. Silver, Diana, PhD, MPH, Associate Professor of Global Public Health and Public Health Policy, Co-Director, Public Health Policy Lab, School of Global Public Health, New York University

415. Silverman, Hannah, MPH, Senior Research Associate, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

416. Silverman, Jay, PhD, Professor of Medicine and Global Public Health, University of California San Diego School of Medicine

417. Simeoni, Diane, MS, Certified Genetic Counselor, Envision Healthcare

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

419. Sisson, Gretchen, PhD, Research Sociologist, Department of Obstetrics, Gynecology, and

Reproductive Science, University of California, San Francisco

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

421. Smith, Emily R., ScD, MPH, Assistant Professor, Departments of Global Health & Exercise & Nutrition Sciences, Milken Institute School of Public Health, The George Washington University

422. Sonalkar, Sarita, MD, MPH, Assistant Professor of Obstetrics and Gynecology, Division of Family Planning, University of Pennsylvania Health System

423. Sonenstein, Freya Lund, PhD, Professor Emerita, Johns Hopkins Bloomberg School of Public Health

424. Stearns, Sally, PhD, Professor, Department of Health Policy and Management, The University of North Carolina at Chapel Hill

425. Stekler, Joanne, MD, MPH, Associate Professor, Division of Infectious Diseases Adjunct Associate Professor, Epidemiology and Global Health, University of Washington

426. Stevens, Blair, MS, CGC, Assistant Professor, Director, Prenatal Genetic Counseling Services, Department of Obstetrics, Gynecology

and Reproductive Sciences, UTHealth McGovern Medical School

427. Stillman, Melissa, MPH, Senior Research Associate, Guttmacher Institute

428. Stockman, Jamila K., PhD, MPH, Vice Chief, Global Public Health Section, Professor, Co-Director, CFAR, Health Equity Sociobehavioral Science Core, Division of Infectious Diseases & Global Public Health, Department of Medicine, University of California, San Diego

429. 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

430. Stuart, Gretchen S., MD, MPH, Professor, UNC Chapel Hill

431. Subak, Leslee L., MD, Katharine Dexter McCormick and Stanley McCormick Memorial Professor, Chair, Department of Obstetrics and Gynecology, Professor, by Courtesy, Department of Urology, Stanford University School of Medicine

432. Suski, Emily, JD, LLM, MSW, Associate Professor, School of Law, University of South Carolina

433. Suter, Sonia M., JD, MS, Professor of Law, The Kahan Family Research Professor of Law, Co-Director, Health Law & Policy Program, The George Washington University Law School

434. Suthar, Laxmi, MD, FACP, Program Director UCLA – Olive View Internal Medicine Residency, David Geffen School of Medicine Associate Professor of Medicine

435. Swedish, Kristin A., MD, MPH, Assistant Professor of Medicine, Albert Einstein College of Medicine, Associate Program Director, Montefiore Wakefield Internal Medicine Residency Program

436. Swendeman, Dallas, PhD, MPH, Associate Professor, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, Affiliated Faculty, Department of Epidemiology, Fielding School of Public Health, Co-Director, Center of Expertise on Women's Health, Gender & Empowerment in the U.C. Global Health Institute, Co-Director, Development Core, Center for H.I.V. Identification, Prevention & Treatment Services, University of California, Los Angeles

437. Swenor, Bonnielin, PhD, MPH, Director, Endowed Professor of Disability Health and Justice, Disability Health Research Center, Johns Hopkins University

438. Tang, Jennifer, MD, MSCR, FACOG, Associate Professor, UNC Department of OB-GYN

439. Tavrow, Paula, Ph.D., Adjunct Professor, Department of Community Health Sciences, University of California Los Angeles Fielding School of Public Health

440. Teague, Emily K., MS, LCGC, Licensed Genetic Counselor, The Center for Medical Genetics, Wentworth Health Partners

441. Therrien, Michelle Skaer, MPH, Global Project Director, Bixby Center for Global Reproductive Health, University of California San Francisco

442. Thiel de Bocanegra, Heike, PhD, MPH, Dorothy J. Marsh Endowed Chair in Reproductive Biology, Adjunct Professor, Obstetrics and Gynecology, School of Medicine, University of California, Irvine

443. Thoma, Marie E., PhD, Associate Professor, Department of Family Science, School of Public Health, University of Maryland

444. Thompson, Lauren Maclvor, PhD, Faculty Research Fellow, Center for Law, Health, Society, Georgia State University College of Law, Assistant Professor of History and Interdisciplinary Studies, Kennesaw State University

445. Thompson-Lastad, Ariana, PhD, Assistant Professor of Family and Community Medicine, Osher Center for Integrative Health, University of California San Francisco

446. Ti, Angeline, MD, MPH, FAAFP, Faculty, Wellstar Douglas Family Medicine Residency Program

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

448. Tillema, Sarah, MHS, PA-C, University of Colorado School of Medicine

449. Tober, Diane, PhD, Assistant Professor, Institute for Health and Aging, School of Nursing, University of California, San Francisco

450. Tonascia, James, PhD, Professor of Biostatistics and Epidemiology, John Hopkins University Bloomberg School of Public Health

451. Torrant, Elizabeth, MPH, Chief Program Officer, Health Imperatives

452. Tsui, Amy O., PhD, Professor Emerita, Population, Family and Reproductive Health Department, Johns Hopkins Bloomberg School of Public Health

453. Tsuyuki, Kiyomi, Ph.D., MPH, Assistant Professor, Division of Infectious Diseases & Global Public Health, Department of Medicine, University of California, San Diego

454. Tyburczy, Jennifer, PhD, Associate Professor of Feminist Studies, University of California, Santa Barbara

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

456. VanLandingham, Mark J., PhD, Thomas C. Keller Professor, Director, Center for Studies of Displaced Populations, Department of Social, Behavioral, and Population Sciences, Department of International Health and Sustainable Development, Tulane University School of Public Health and Tropical Medicine

457. Ventura, Stephanie J., MA, Retired Chief of the Reproductive Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention

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

459. Vilda, Dovile, PhD, MSc, Research Assistant Professor, Mary Amelia Center for Women's Health Equity Research, Department of Social, Behavioral, and Population Sciences, Tulane University School of Public Health and Tropical Medicine

460. Volmar, Karen, JD, MPH, FACHE, Professor of Health Policy and Management

461. 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

462. Wagman, Jennifer A., PhD, MHS, Assistant Professor, Department of Community Health Sciences, University of California Los Angeles, Fielding School of Public Health

463. Waldman, Ronald, MD, MPH, Professor Emeritus of Global Health, Milken Institute School of Public Health, The George Washington University

464. Wallace, Maeve, PhD, MPH, Associate Professor, Department of Health Promotion Sciences, Mel and Enid Zuckerman College of Public Health, University of Arizona

465. Warden, Meredith, MD, MPH, Ryan Program Director, Department of Obstetrics and Gynecology, Kaiser Permanente East Bay

466. Warthin, Caitlin, MPH, Senior Program Officer, Averting Maternal Death and Disability Program, Columbia University Mailman School of Public Health

467. Wasserman, Alan G., MD, MACP, Eugene Meyer Emeritus Professor of Medicine,

Department of Medicine, The George Washington School of Medicine and Health Sciences

468. Watnick, Dana, PhD, MPH, MSSW, Assistant Professor, Albert Einstein College of Me

469. Watson, Sidney D., JD, Jane and Bruce Robert Professor of Law, Center for Health Law Studies, Saint Louis University School of Law

470. Wawer, Maria J., MD, MHSc, Professor, Department of Epidemiology, Joint Appointment, Department of Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Joint Appointment, Professor, Department of Medicine, Division of Infectious Diseases, Johns Hopkins School of Medicine, Professor, Heilbrunn Department of Family and Reproductive Health, Mailman School of Public Health, Columbia University, New York

471. Wayne, Nancy L., PhD, Professor of Physiology, David Geffen School of Medicine, University of California, Los Angeles

472. Weinberger, Morris, PhD, Vergil N. Slee Distinguished Professor of Healthcare Quality Management, Chair, Department of Health Policy and Management, UNC Gillings School of Global Public Health

473. Weisman, Carol S., PhD, Distinguished Professor Emerita of Public Health Sciences, Penn State College of Medicine

474. Wessells, Michael, MD, Professor, Program on Forced Migration and Health, Columbia University Mailman School of Public Health

475. West, Jr., Keith P., DrPH, R.D., George G. Graham Professor of Infant and Child Nutrition, Program in Human Nutrition, Department of International Health, Johns Hopkins Bloomberg School of Public Health

476. Wheatley, Catherine, MD, FACOG, Assistant Professor, Obstetrics and Gynecology, Undergraduate Medical Education Director, Obstetrics and Gynecology, Phase 2/3 Management Committee Co-Chair, College of Medicine, Department of Obstetrics and Gynecology, University of Illinois Chicago College of Medicine

477. Whitaker, Amy, MD, Chief Medical Officer, Planned Parenthood of Illinois, Clinical Associate Professor, University of Chicago, Department of OB/GYN

478. Wilets, James D., JD, Professor of Law, Shepard Broad College of Law

479. Williams, Caitlin R., MSPH, Research Consultant, Department of Maternal & Child Health, Gillings School of Global Public Health, University of North Carolina Chapel Hill

480. Williams, Sabrina R., MS, CGC, Licensed, Certified Genetic Counselor, MHUP High Risk OB Care

481. Winch, Peter, MD, MPH, Professor, Social and Behavioral Intervention Program, Department of International Health, Johns Hopkins Bloomberg School of Public Health

482. Wirtz, Andrea L., PhD, MHS, Associate Professor, Center for Public Health and Human Rights, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health

483. Wood, Jill M., PhD, Teaching Professor, Department of Women's, Gender, and Sexuality Studies, Penn State University

484. Wood, Shannon N., PhD, MSc, Assistant Professor, Department of Population, Family and Reproductive Health, Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

485. Wynia, Matthew, MD, MPH, FACP, Professor, Schools of Medicine and Public Health, Director, Center for Bioethics and Humanities, University of Colorado Anschutz Medical Campus

486. Yarborough, Mark, PhD, Dean's Professor of Bioethics, Bioethics Program, Professor,

Internal Medicine, University of California, Davis

487. Yepes-Ríos, Ana Mónica, MD, FACP, Associate Professor, Department of Medicine, Cleveland Clinic Lerner College of Medicine, Case Western University

488. Zeal, Carley, MD, MPH, FACOG, Obstetrician/Gynecologist – Attending Physician, MercyHealth Beloit – MercyHealth Janesville

489. Zite, Nikki B., MD, MPH, Professor, Vice Chair of Education and Advocacy, Department of OB/GYN, University of Tennessee Graduate School of Medicine

490. Zug, Marcia, JD, Miles and Ann Loadholt Professor of Family Law, University of South Carolina School of Law