19-2690

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

LITTLE ROCK FAMILY PLANNING SERVICES, ET AL.,
PLAINTIFFS-APPELLEES,

V.

LESLIE RUTLEDGE, IN HER OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE STATE OF ARKANSAS, ET AL.,
DEFENDANTS-APPELLANTS.

On Appeal from the United States District Court
for the Eastern District of Arkansas
No. 4:19-cv-00449-KGB
Hon. Kristine G. Baker, Judge

BRIEF FOR AMICI CURIAE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, MAINE, MARYLAND, MASSACHUSETTS, MINNESOTA, NEVADA, NEW MEXICO, NEW YORK, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, WASHINGTON, AND THE DISTRICT OF COLUMBIA IN SUPPORT OF APPELLEES AND AFFIRMANCE

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INTERESTS OF AMICI CURIAE AND SUMMARY OF THE ARGUMENT

Reproductive healthcare gives women the ability "to participate equally in the economic and social life of the Nation" and to maintain control over their reproductive lives. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (plurality op.). Earlier this year, Arkansas passed both an 18-week Abortion Ban, prohibiting women from obtaining an abortion after 18 weeks, and a Reason Ban, prohibiting a physician from intentionally performing or attempting to perform an abortion "with the knowledge" that a pregnant woman is seeking an abortion "solely on the basis" of: a test "indicating" Down syndrome, a prenatal diagnosis of Down syndrome, or "[a]ny other reason to believe" the "unborn child" has Down syndrome. Because these Bans prohibit women from exercising their right to obtain an abortion before viability, they are plainly unconstitutional. *Casey*, 505 U.S. at 856. Amici States California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia support plaintiffs-appellees in overturning the Bans and, more generally, support access to pre-viability abortion and contraceptives.[1]

[1] Amici file this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2).

Arkansas's Bans threaten amici States' interests. Residents of amici States may need access to reproductive healthcare while studying, working, or visiting in Arkansas, and as the record reflects, physicians licensed in amici States practice medicine in Arkansas. ADD21 (reflecting that California physician practices in Arkansas). Amici States are also concerned that, as Arkansas admits, its restrictive abortion laws will cause women to seek abortion care in other States, thereby straining the healthcare systems of the amici States. Appellant's Opening Brief (AOB) at 5; *see also Norton v. Ashcroft*, 298 F.3d 547, 558 (6th Cir. 2002) (citing Congressional testimony that "patients must often travel interstate to obtain reproductive health services").

Amici States recognize and share Arkansas's interests in protecting the health of all women, including women of childbearing age. But reducing or eliminating access to safe and legal abortion leads to worse health outcomes for women. Amici States write to highlight some of the ways in which they have promoted women's health, including taking concrete steps to reduce maternal mortality rates. Their experiences demonstrate that States can advance women's health while still protecting women's constitutionally protected rights.

Amici States also recognize and share Arkansas's interests in affirming the dignity of persons with Down syndrome, ensuring that women facing reproductive choices do not act on outdated information or harmful stereotypes about Down

syndrome, and protecting the integrity of the medical profession. Amici States are committed to advancing such interests in a manner consistent with the States' constitutional obligation to protect women's reproductive rights.[2]

ARGUMENT

I. ARKANSAS'S FLAT PROHIBITION OF CERTAIN CATEGORIES OF PRE-VIABILITY ABORTION IS UNCONSTITUTIONAL

Nearly half a century ago, the Supreme Court recognized that women have a constitutional right to choose an abortion before viability. *Roe v. Wade*, 410 U.S. 113, 163 (1973). In 1992, the Supreme Court reaffirmed *Roe*'s "essential holding" that, before viability, "the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846. In the years that followed, the Supreme Court and this Court have repeatedly made clear that "[b]efore viability, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy." *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (per curiam) (holding 12-week abortion ban unconstitutional).[3]

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[2] Although this brief only addresses the Abortion Ban and the Reason Ban, the States support the district court's decision regarding the OBGYN Requirement.

[3] *See also Jackson Women's Health Organization v. Dobbs*, 2019 WL 6799650, at *1-5 (5th Cir. Dec. 13, 2019) (Mississippi's 15-week abortion ban unconstitutional); *Isaacson v. Horne*, 716 F.3d 1213, 1222-23 (9th Cir. 2013) (20-week ban unconstitutional).

Arkansas's Bans ignore this controlling precedent. With only a few narrow exceptions, the 18-week Abortion Ban prohibits women in Arkansas from seeking abortions after eighteen weeks—thus barring them from getting an abortion for several weeks before viability. *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (assessing viability at "about 24 weeks"); *see also* ADD97 ("a normally developing fetus will not attain viability until at least 24 weeks"). Likewise, the Reason Ban prohibits women from seeking abortions at any point prior to viability based on certain reasons for pursuing abortion care disfavored by Arkansas lawmakers. The district court correctly held that no state interest can justify a ban on abortion prior to viability. *Little Rock Family Planning Services*, 397 F. Supp. 3d 1213, 1265-1269, 1273 (E.D. Ark. 2019). This Court should affirm on that basis.

II. CUTTING SHORT THE TIME PERIOD IN WHICH WOMEN CAN EXERCISE THEIR CONSTITUTIONAL RIGHTS HARMS WOMEN'S HEALTH

Arkansas asserts that its ban on abortions after 18 weeks is aimed at protecting maternal health. AOB at 23. Its ban, however, disserves that purpose. It is well-established that the best way to advance women's health is to provide meaningful access to a comprehensive range of reproductive healthcare services, including abortion.[4] Both the American Medical Association (AMA) and the

[4] Position Paper, Am. Coll. of Physicians, *Women's Health Policy in the United States*, Ann. Intern. Med. 2018; 168(12) at 876-77.

American College of Obstetricians and Gynecologists (ACOG) agree that "[a]ccess to safe and legal abortion benefits the health and wellbeing of women and their families."[5] Indeed, overwhelming scientific evidence establishes that highly restrictive abortion laws (like Arkansas's) lead to *worse* health outcomes for women and also fail to lower abortion rates.[6] Moreover, there is a direct connection between restrictive abortion laws and *higher* maternal mortality rates.[7]

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[5] *Abortion Policy*, Am. Coll. of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Abortion-Policy?IsMobileSet=false; Complaint, Dkt. No. 1, at 5 (¶ 16), *Am. Medical Ass'n, et al. v. Stenehjem*, Dist. Ct. of North Dakota, No. 19-cv-125, (June 25, 2019).

[6] *See* ADD51 (finding that abortion is "substantially safer than giving birth"); ADD109 ("[r]ecord evidence supports that legal abortion is significantly safer for a woman than carrying a pregnancy to term and giving birth"); *see also* JA0151-152 (Dr. Ho Decl. at ¶ 20 ("Carrying a pregnancy to term and delivering the baby is significantly riskier than abortion. The national risk of maternal mortality associated with live birth is approximately fourteen times higher than that associated with induced abortion. In Arkansas, the maternal mortality rate is even worse, with Arkansas ranked 44th in the nation for maternal mortality compared to other states in 2018")); JA0183-184 (Dr. Hopkins Decl. at ¶¶ 26-28 (explaining that "abortion is dramatically safer than carrying a pregnancy to term")); *Induced Abortion Worldwide*, Guttmacher Inst., 1-2 (March 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_iaw.pdf ("Abortion rates are similar in countries where abortion is highly restricted and where it is broadly legal."); Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, Women's Health Issues (2016), https://www.sciencedirect.com/science/article/pii/S1049386715001589.

[7] *See* Su Mon Latt, et al., *Abortion Laws Reform May Reduce Maternal Mortality; An Ecological Study in 162 Countries*, BMC Women's Health 19, Article Number: 1 (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-

As the experience of amici States demonstrates, States have a range of options to promote women's healthcare; they need not do so by restricting a woman's constitutional right to choose what is right for her, her health, and her family.

A. States' Interest in Promoting Women's Health is Served by Ensuring Access to Pre-Viability Abortion

Barriers to abortion access cause negative health consequences. Concern about health and well-being may lead a woman to decide to seek an abortion. Women forced to carry an unwanted pregnancy to term risk postpartum hemorrhage and eclampsia, and report a need to limit physical activity for a period three times longer than women who receive abortions.[8] For women who have pregnancies too close together, the Mayo Clinic warns of several health risks to the woman and her child, including an increased risk of premature birth, low birth weight, congenital disorders, and schizophrenia.[9] Additionally, for some women,

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018-0705-y (study of 162 countries over a 28-year time period, concluding that "maternal mortality is lower when abortion laws are less restrictive" and countries with the most restrictive abortion laws suffered 45 more maternal deaths per 100,000 live births than countries where safe and legal abortion was available).

[8] Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, Women's Health Issues (2016), https://www.sciencedirect.com/science/article/pii/S1049386715001589.

[9] *Family Planning: Get the facts about Pregnancy Spacing*, Mayo Clinic, https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072.

carrying an unwanted pregnancy to term can result in her remaining in contact with a violent partner and suffering physical violence.[10]

Lack of access to abortion also results in poorer socioeconomic outcomes, including lower rates of full-time employment and increased reliance on publicly funded safety-net programs.[11] Conversely, increased availability of abortion results in *increased* women's participation in the workforce, especially for women of color.[12] Abortion access also results in reduced unintended births, and when children are planned, they have improved educational and economic outcomes both during childhood and later in life. *Id*.

When States cut short the time in which women may exercise their right to obtain an abortion, the issues described above are compounded.[13] The

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[10] Sarah C.M. Roberts, et al., *Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion*, BMC Medicine (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182793/.

[11] Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, Am. J. Pub. Health 103, no. 3, at pp. 407-413 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/.

[12] *See* Anna Bernstein, et al., *The Economic Effects of Abortion Access: A Review of the Evidence*, Center for Economics of Reproductive Health, Institute for Women's Policy Research (2019), at v., https://iwpr.org/wpcontent/uploads/2019/07/B379_Abortion-Access_rfinal.pdf.

[13] The effects of Arkansas's abortion ban are amplified by Arkansas's other obstacles to obtaining an abortion, such as a mandatory 72-hour waiting period after receiving state-mandated information, requiring that women make two

overwhelming majority of women who have an abortion in the second trimester "would have preferred to have had their abortion earlier," but were unable to do so due to factors including cost and access barriers.[14] And "[i]n part because of their increased vulnerability to these barriers, low-income women and women of color are more likely than are other women to have second trimester abortions."[15] It is these women who will suffer as a result of the unconstitutional abortion restrictions like the one at issue here.[16] Women who learn of fetal anomalies or develop

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separate trips to the clinic before obtaining an abortion. ADD26, ADD19; *see also* JA0185 (Dr. Hopkins Decl. at ¶ 31 (explaining that these restrictions result in increased delays to access to care and create barriers that are particularly problematic for patients living in or near poverty or without insurance, as well as for patients who cannot take multiple days off from work without jeopardizing their jobs as they must either drive long distances multiple times or pay for three nights in a hotel, plus arrange for childcare)).

[14] Lawrence B. Finer, et al., *Timing of steps and reasons for delays in obtaining abortions in the United States*, Contraception, 74(4):334, 341 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/10/17/Contraception74-4-334_Finer.pdf; JA0184-185 (Dr. Hopkins Decl. at ¶ 30 (explaining "[p]atients generally try to get an abortion as early in their pregnancy as they are able")).

[15] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. of Pub. Health 623, 624 (Apr. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661467/.

[16] Am. Coll. of Obstetricians and Gynecologists, Comm. Op. No. 613, *Increasing Access to Abortion* 5 (Nov. 2014). One recent study, for example, found a higher likelihood of second-trimester abortion among women who needed financial assistance to be able to afford an abortion or lived 25 miles or more from an appropriate healthcare facility. *See* Rachel K. Jones and Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and*

complications relating to their own health during pregnancy would also be disproportionately affected by Arkansas's law, as many of these developments are first detected during the second trimester.[17]

Moreover, it is already difficult to access abortion in some parts of the country, including in Arkansas, which only has two clinics that provide abortions.[18] Although it is a "common medical procedure," many large cities in the United States do not have any clinics that offer abortions.[19] Women who live in 27 major U.S. cities have to travel more than 100 miles to reach an abortion facility.[20] In 2014, women in Arkansas had to travel a median distance of 48.35

Second-Trimester Abortions, PLOS ONE, 12(1), 1 (2007), http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169969.

[17] Boaz Weisz, et al., *Early Detection of Fetal Structural Abnormalities*, 10 Reproductive BioMedicine Online 541-553 (2005), https://doi.org/10.1016/S1472-6483(10)60832-2; ADD19 (finding that some fetal anomalies are discovered through testing that cannot occur until 18 to 20 weeks); *id*. (some patients seek an abortion at or after 18 weeks because they have a medical condition that does not become apparent until that time, or an existing medical condition that worsens during the course of pregnancy).

[18] ADD 165; Rachel K. Jones, et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. at 18 (2017), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf.

[19] Alice Cartwright, et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search* (2018), https://www.jmir.org/2018/5/e186/.

[20] *Id*.

miles to obtain an abortion.[21] And in 2017, about 89% of U.S. counties—home to 38% of all women between the ages of 15-44—lacked an abortion clinic, and five states had only one clinic in the entire state.[22] In Arkansas, 97% of Arkansas counties have no clinic that provides abortion and 77% of Arkansas women live in those counties.[23]

These reproductive healthcare "deserts" lead to the adverse consequences described above, including delays in care, negative mental health impacts, and consideration of self-induced abortion.[24] Furthermore, these healthcare deserts, that are the result of restrictive laws like Arkansas, end up impacting other States. Indeed, Arkansas readily admits that it relies on other States to pick up the costs of

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[21] *See* Jonathan M. Bearak, et al., *Disparities and change over time in distance women would need to travel to have an abortion in the USA: a spatial analysis* (2017), https://doi.org/10.1016/S2468-2667(17)30158-5.

[22] Rachel K. Jones, et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (2017), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf; *see also* JA0106 (Dr. Freedman Decl. at ¶ 5).

[23] JA0106 (Dr. Freedman Decl. at ¶ 5).

[24] Alice Cartwright, et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search* (2018), https://www.jmir.org/2018/5/e186/; Jenna Jerman, et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, Perspective Sex Report of Health (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5953191/#R3.

helping their women residents. AOB at 5 (admitting that Arkansas women will need to travel to "neighboring States" to obtain necessary healthcare).[25]

B. States Can Promote Women's Health Without Curtailing Women's Ability to Exercise their Constitutional Right to Choose

Amici States agree with Arkansas that States have an essential role to play in protecting and improving the health of women of childbearing age. In many circumstances, reasoned legislative judgments regarding healthcare receive a substantial degree of respect from courts. No principle, however, requires or permits uncritical judicial acceptance of legislative judgments that improperly discount—or even countenance—increased risks to women's health. *See Whole Women's Health*, 136 S. Ct. at 2309-2318; *Gonzales*, 550 U.S. at 165.

Moreover, there are a number of proven measures that States can take to advance women's health that do not include limiting access to abortion, as the experience of amici States illustrates. For instance, Illinois maintains a Family Planning Program that provides high-quality pregnancy planning services to low-

[25] *See also* ADD29 (finding that women in Arkansas will be "forced to travel out of state to obtain" necessary care); ADD30-32 (discussing impacts of additional travel, including out-of-state travel); ADD53-54; JA0149 (Dr. Ho Decl. at ¶ 11 (explaining that women travel across state lines when their State fails to offer necessary healthcare services, including abortion care)); JA0178 (Dr. Hopkins Decl. at ¶ 8 (explaining that Arkansas women will "leave the state to obtain care")).

income individuals, thereby lowering the incidence of unintended pregnancies and sexually transmitted diseases; providing HIV testing and counselling; and offering special teen clinics.[26] Similarly, Maryland's Maternal, Infant, and Early Childhood Home Visiting program funds home visiting programs to address prenatal care, infant mortality, childhood immunizations, child abuse and neglect, and school readiness.[27] Maryland also provides educational training to hospital maternity staff to meet the Maryland Hospital Breastfeeding Policy Recommendations and Maryland's Baby Friendly Hospital Initiative.[28] *See also* Amicus Br. for State of California et al. at 14-34, *Jackson Women's Health Org. v. Dobbs*, No. 19-60455, 2019 WL 5099416 (5th Cir. Oct. 4, 2019) (collecting information about state initiatives to promote women's health).

Several amici States also have laws and maintain programs to increase access to contraceptives. If a State's goal is to reduce the number of abortions, then increasing access to effective contraception "dramatically reduces unwanted

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[26] *Family Planning*, Ill. Dep't of Pub. Health, http://dph.illinois.gov/topics-services/life-stages-populations/womens-health-services/family-planning.

[27] *Overview of Home Visiting in Maryland*, Md. Dep't of Health, https://phpa.health.maryland.gov/mch/Pages/hv-background.aspx.

[28] *Hospital Breastfeeding Policy Maternity Staff Training*, Md. Dep't of Health, https://phpa.health.maryland.gov/mch/Pages/Hospital_Breastfeeding_Policy_Training.aspx.

pregnancies and reduces the abortion rate." [29] For instance, several States require State-regulated health plans to cover all FDA-approved contraceptive drugs, devices, products, and services for women without cost-sharing. *See, e.g.*, D.C. Code § 31-3834.03; Nev. Rev. Stat. §§ 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, and 695C.1696; N.Y. Insurance Law § 3221(*l)*(16). In terms of programs, New Mexico's family planning program offers clinical services including laboratory tests, counselling, and birth control, while supporting community-based programs for teens, including comprehensive sex education and adult-teen communication programs. Similarly, the New York Comprehensive Family Planning & Reproductive Health Program provides low-income women, men, and communities of color with access to affordable high quality family

[29] Reva B. Siegel, *ProChoiceLife: Asking Who Protects Life and How—and Why It Matters in Law and Politics*, 93 Ind. L.J. 207, 208 n.5 (2018) (collecting studies). For example, in 2007, Colorado launched the Family Planning Initiative providing low- or no-cost long-acting reversible contraceptives (LARCs) to low-income women. By mid-2015, the initiative provided LARCs to more than 36,000 women. As a result, the birth and abortion rates both declined by nearly 50% among teens aged 15-19, and by 20% for young women aged 20-24. It is estimated that Colorado avoided over $50 million in public assistance costs associated with unintended pregnancies. *Taking the Unintended Out of Pregnancy: Colorado's Success with Long-Acting Reversible Contraception*, Colo. Dep't of Pub. Health and Env't (Jan. 2017), https://www.colorado.gov/pacific/sites/default/files/PSD_TitleX3_CFPI-Report.pdf.

planning care.[30] In 2017, 21.5% of the female clients served by the program left the clinic with what is deemed a "most effective" contraceptive (a long acting reversible contraceptive) and 67.5% of the female clients left with a "moderately effective" contraceptive method (such as prescription birth control pills).[31]

With these types of measures, amici States have made significant strides in reducing maternal mortality rates.[32] The United States has the highest rate of maternal mortality in the developed world, and Arkansas has one of the highest rates of maternal mortality in the country.[33] Nationally, more than 700 women die

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[30] *Comprehensive Family Planning and Reproductive Health Care Services Program*, N.Y. State Dep't of Health, https://www.health.ny.gov/community/pregnancy/family_planning/.

[31] Lauren Tobias Decl., *State of Oregon v. Azar*, Dist. Ct. of Oregon, No. 19-cv-00317, Dkt. No. 66, at 7 (March 21, 2019); *id*. at 6 (In 2017, this program served 301,128 clients at 470,973 family planning visits and the program successfully reached underserved communities).

[32] *See e.g.*, Renee Montagne, *To Keep Women From Dying In Childbirth, Look To California*, Nat'l Pub. Radio (July 29, 2018), https://www.npr.org/2018/07/29/632702896/to-keep-women-from-dying-in-childbirth-look-to-california; Fran Kritz, *California's Infant Mortality Rate Reaches Record Low*, Cal. Health Report (Jan. 14, 2014), http://www.calhealthreport.org/2014/01/14/californias-infant-mortality-rate-reaches-record-low/. *See also California's Infant Mortality Rate is Lower than the Nation's and Has Reached a Record Low*, Let's Get Healthy California, https://letsgethealthy.ca.gov/goals/healthy-beginnings/reducing-infant-mortality/.

[33] Nina Martin & Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, Nat'l Pub. Radio (May 12, 2017), https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-

of pregnancy-related complications and more than 50,000 women experience a life-threatening complication every year.[34] While the majority of countries worldwide are reporting declining maternal mortality rates, the numbers in the United States are rising. From 2000 to 2014, maternal mortality in the United States has more than doubled, from 9.8 deaths per 1,000 live births in 2000 to 21.5 deaths per 1,000 live births in 2014.[35] Compared to women in Canada and the United Kingdom, women in the United States are over three times more likely to die from complications relating to childbirth.[36] These alarming numbers prompted Congress to pass the bipartisan Preventing Maternal Deaths Act of 2017.[37] Similarly, several amici States took prompt and decisive action by enacting

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developed-world; ADD15 (finding that Arkansas is ranked 44th in the nation for maternal mortality compared to other states).

[34] Michael C. Lu, *Reducing Maternal Mortality in the United States*, JAMA (Sept. 25, 2018), https://jamanetwork.com/journals/jama/article-abstract/2702413.

[35] *Id*. Many of the states with the highest maternal death rates are states with restrictive abortion laws. The top three states are Georgia, Louisiana, and Indiana, with 46.2, 44.8, and 41.4 maternal deaths per 100,000 births, respectively. *See* United Health Found., America's Health Rankings (2018), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/AK.

[36] *Id*. In fact, the United States "is the only country outside Afghanistan and Sudan where the [maternal mortality] rate is rising." *Alliance for Innovation on Maternal Health Program*, Council on Patient Safety in Women's Health Care, https://safehealthcareforeverywoman.org/aim-program/.

[37] H.R. 1318 – *Preventing Maternal Deaths Act 2018* (2017-2018), https://www.congress.gov/bill/115th-congress/house-bill/1318?s=1&r=2.

legislation to promote women's health and curb this distributing trend. For instance, California initiated the California Maternal Quality Care Collaborative, a multi-stakeholder organization committed to ending preventable morbidity, mortality, and racial disparities in California's maternity care.[38] And these efforts have borne fruit. California has seen maternal mortality decline by 57% between 2006 to 2013, from 16.9 to 7.3 deaths per 100,000 live births.[39] Among the 50 states, maternal mortality is the lowest in California.[40]

In amici States' experience, policies that that support the health of pregnant women also benefit the health of their future children. As described *supra*, amici States have promoted women's health by expanding access to healthcare services and contraceptives, supporting maternal and infant healthcare programs, and offering educational and counselling services.

Protecting women's health is a core responsibility of all States. As amici States' policies and programs demonstrate, there are many ways States can

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[38] *Who We Are*, Cal. Maternal Quality Care Collaborative, https://www.cmqcc.org/who-we-are.

[39] *Pregnancy Associated Mortality Review*, Cal. Dep't of Pub. Health, https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Communications/Profile-PAMR.pdf.

[40] *The States with the Highest (and Lowest) Maternal Mortality, Mapped*, Advisory Board (Nov. 9, 2018), https://www.advisory.com/daily-briefing/2018/11/09/maternal-mortality.

effectively promote women's health without infringing on women's constitutional right to access abortion services.

III. DISPELLING STEREOTYPED AND OUTDATED VIEWS ABOUT PERSONS WITH DISABILITIES NEED NOT COME AT THE EXPENSE OF WOMEN'S REPRODUCTIVE HEALTHCARE

Amici States agree with Arkansas that States have a strong interest in combatting discrimination against persons living with disabilities, and in dispelling outdated and harmful views about disabilities, including Down syndrome. As the district court held, however, these interests are insufficient to justify Arkansas's outright "Reason Ban" on pre-viability abortions. *Little Rock Family Planning Services*, 397 F. Supp. 3d at 1273; *see also Planned Parenthood of Indiana and Kentucky, Inc. v. Commissioner of Indiana State Dep't of Health*, 888 F.3d 300, 306-307 (7th Cir. 2018), *cert. granted in part, judgment rev'd on other grounds sub. nom. Box v. Planned Parenthood of Indiana & Kentucky, Inc.*, 139 S. Ct. 1780 (2019). Moreover, it is the experience of amici States that dispelling discriminatory views about Down syndrome and protecting women's access to reproductive healthcare are not at odds. To the contrary, States have at their disposal a range of options to further the interests asserted by Arkansas without infringing on women's constitutional rights, including promoting accurate and non-biased information about Down syndrome, enforcing anti-discrimination laws, and providing supportive services for individuals living with Down syndrome and

their families. Indeed, protecting individuals with disabilities while simultaneously protecting women's reproductive rights furthers fundamental principles of autonomy and self-determination.

A. States Have a Range of Tools to Provide Accurate, Non-discriminatory Information About Developmental Disabilities Such as Down Syndrome

The district court's injunction does not leave States powerless to remedy alleged discrimination and misinformation about disabilities, as the States supporting Arkansas suggest. *Cf.* Missouri Amicus Br. at 27. States can and do promote provision of medically accurate, unbiased information in order to help women make informed reproductive choices. States can also provide (and publicize) civil rights protections, social and medical services, and support to those living with developmental disabilities and their families. These efforts combat discrimination, reduce bias among doctors and patients, and protect the Down syndrome community without infringing on women's reproductive autonomy.[41]

[41] Missouri, citing Congressional testimony by Frank Stephens, suggests that there are "[r]ecent efforts to 'eliminate' Down syndrome" by pushing for a "particular final solution." Missouri Amicus Br. at 26-27. But, at the *same* congressional hearing, Dr. Joaquin Espinosa, Executive Director of the Linda Crnic Institute for Down Syndrome, testified that it is a "misperception" that "the population with Down syndrome would eventually disappear due to early pre-natal screening." "In the U.S.A., the rate of live births with Down syndrome has actually *increased* over the last three decades, currently being at around 1 in 700." Dr. Joaquin Espinosa, at 3, https://docs.house.gov/meetings/AP/AP07/20171025/106526/HHRG-115-AP07-Wstate-EspinosaJ-20171025.pdf.

Pro-information laws circulate accurate, non-biased information to dispel discriminatory stereotypes and prejudices regarding individuals with Down syndrome within the medical profession and society at large. In 2010, Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act, which seeks to "coordinate the provision of, and access to, new or existing supportive services for patients receiving a positive diagnosis for Down syndrome." 42 U.S.C. § 280g-8(b)(1)(B). The law expanded the National Dissemination Center for Children with Disabilities, peer-support programs, adoption registries, awareness and education programs for healthcare providers, and the dissemination of information relating to Down syndrome. 42 U.S.C. § 280g-8.

A number of States have passed their own pro-information laws. These laws make evidence-based information about Down syndrome available to those who receive a prenatal indication of Down syndrome, including unbiased information on the outcomes, life expectancy, development, and treatment options for those living with Down syndrome. *See* 16 Del. Code § 801B; Mass. Gen. Laws Ann. ch. 111, § 70H(b); Md. Code, Health-Gen. § 20-1501-1502; Minn. Stat. § 145.471; N.J. Stat. Ann. §§ 26:2-194, 26:2-195; 35 Pa. Stat. §§ 6241-44; Va. Code §54.1-2403.1(B). These laws can help healthcare providers transmit accurate, non-stigmatizing information, while leaving the ultimate decision of whether to terminate a pregnancy to the woman whose right it is to make this personal choice.

The Arkansas Down Syndrome Association, whose mission it is to "empower people with Down Syndrome and their families by promoting community education, evidence based healthcare, and social opportunities" explains that "[w]hether or not to undergo prenatal screening or diagnostic testing [for Down syndrome] is a personal decision, and expectant parents must make the choice that is best for them."[42] The Association further provides that, after diagnostic testing, "[i]t is important that [families] receive accurate information and understand all [] options."[43] For instance, some families once learning about a diagnosis begin "mak[ing] preparations (like informing other family members and doing research on Down syndrome) prior to the birth," while other parents "make arrangements for adoption," as there is "a long waiting list of families in the United States ready

[42] Arkansas Down Syndrome Association, https://ardownsyndrome.org/about-us/our-purpose-vision/; *A Promising Future Together: A Guide for New and Expectant Parents*, National Down Syndrome Society, at 7, https://ardownsyndrome.org/wp-content/uploads/2018/02/NDSS-NPP-English.pdf; *see also* Dr. Bebbington Decl., Dkt. No. 47-4 at 4 (¶¶ 11-12), *Reproductive Health Servs. of Planned Parenthood of the St. Louis Region v. Parsons*, No. 19-cv-04155-HFS (Aug. 23, 2019) ("Truthfully educating patients is not aimed at discrimination. Rather, providing accurate and complete information to patients about their circumstances is a core responsibility of all physicians").

[43] *A Promising Future Together: A Guide for New and Expectant Parents*, National Down Syndrome Society, at 7, https://ardownsyndrome.org/wp-content/uploads/2018/02/NDSS-NPP-English.pdf.

to adopt a child with Down syndrome," while other parents may "discontinue their pregnancy." *Id*.[44]

Anti-discrimination laws and other civil rights laws enable States to both provide valuable legal protection to individuals living with disabilities, and to fulfill the expressive function of law with a message of inclusion and respect. Just as the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, the

[44] Missouri relies heavily on a declaration from a Dr. McCaffery from its related pending litigation, *Reproductive Health Services of Planned Parenthood of the St. Louis Region v. Parson*, Nos. 19-2882, 19-3134 (8th Cir.). Amicus at 20, 25, 32 (arguing that the "elite medical opinion in America" "lobbied for eugenic 'solutions' to intellectual disabilities"); Amicus Add. However, several declarations rebut Dr. McCaffery's unfounded opinions. For example, one declarant, Dr. Bebbington, explained, "Dr. McCaffery's declaration does not reflect the current state of medical care, including current approaches to counseling patients with fetal diagnoses of Down syndrome and to treating individuals living with Down syndrome. The cruel practices described by Dr. McCaffery have been roundly rejected by the medical profession." Dr. Bebbington Decl., Dkt. No. 47-4 at 4 (¶ 11), *Reproductive Health Servs. of Planned Parenthood of the St. Louis Region v. Parsons*, No. 19-cv-04155-HFS (Aug. 23, 2019); *see also* Dr. Ralston Decl., Dkt. No. 47-2 at 2 (¶ 4), *Reproductive Health Servs. of Planned Parenthood of the St. Louis Region v. Parsons*, No. 19-cv-04155-HFS (Aug. 23, 2019) (disagreeing with Dr. McCaffrey and explaining the unlike Dr. McCaffery, Dr. Ralston "regularly engage[s] in such counseling"); *id*. at 14-15 (¶¶ 38- 41) ("Dr. McCaffery's [ ] views on bias in patient counseling are inaccurate"); Dr. Norton Decl., Dkt. No. 47-1 at 10 (¶¶ 25-26), *Reproductive Health Servs. of Planned Parenthood of the St. Louis Region v. Parsons*, No. 19-cv-04155-HFS (Aug. 23, 2019) ("I disagree with Dr. McCaffery . . . that counseling on Down syndrome is biased. The AMA and the ACOG have made clear that in order to preserve the autonomy of the patient and obtain informed consent with respect to any procedure, a physician must not provide biased or one-sided counseling").

Rehabilitation Act, 19 U.S.C. § 701 *et seq*., and the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 *et seq*., provide federal protections against discrimination for individuals with disabilities, States can—and do—choose to enshrine similar protections in state law.[45] Passage of the landmark Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 *et seq*., helped lead society to have "greater faith in the competencies of citizens with [intellectual and developmental disabilities], and these citizens and their families [to] have higher expectations about the types of lives they will lead."[46]

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[45] *See, e.g*., Cal. Gov't Code §§ 12900-12996 (prohibiting discrimination against individuals with disabilities in employment and housing); Cal. Civ. Code §§ 51, 54.1 (mandating that persons with disabilities have "full and equal access" to public accommodations); Conn. Gen. Stat. §§ 46a-60, 46a-64, 46a-64c and 46a70-76 (prohibiting discrimination based on intellectual disability in employment, public accommodations, housing, and state agency activities); Mass. Gen. Laws ch. 93, § 103 (protecting, among other things, the right to equal participation in any program or activity within the commonwealth); Mass. Gen. Laws ch. 151B, § 4 (prohibiting discrimination in employment and housing); N.J.S.A. § 10:5-5 *et seq*. (providing broad protections against discrimination in a variety of areas, such as public accommodations, employment, housing, etc.); Or. Rev. Stat. §§ 659A.103-659A.145 (protecting persons with developmental disabilities from discrimination); Va. Code §§ 51.5-1, 51.5 (setting forth state policy and rights of individuals with disabilities).

[46] National Council on Disabilities, *Exploring New Paradigms for the Developmental Disabilities Assistance and Bill of Rights Act, Supplement to the 2011 NCD Publication Rising Expectations: The Developmental Disabilities Act Revisited* (2012), at 10, https://www.ncd.gov/rawmedia_repository/NCD_Paradigms_Mar26FIN.pdf.crdownload.pdf.

Furthermore, States can reduce bias and support the Down syndrome community by offering supportive medical and social services to individuals with disabilities, including those with Down syndrome. These types of services "make it possible to meet the needs of families raising children, including children with disabilities."[47] For example, California contracts with twenty-one nonprofit regional centers to provide services for those living with development disabilities, ranging from diagnosis and counseling to advocacy, family support, and planning care.[48] These centers also provide in-home respite care, non-medical care that relieves families from providing constant care to a loved one with a developmental disability.[49] Connecticut's Department of Social Services helps individuals with developmental disabilities live in the community through a variety of community-based residential facilities, and established a Community Residential Facility Revolving Loan Fund for construction and renovation of community residences, supportive employment programs, funding for day care programs, recreational

[47] Sujatha Jesudason & Julia Epstein, The Paradox of Disability in Abortion Debates: Bringing the Pro-Choice and Disability Rights Communities Together, Contraception 84 (2011), 541-543.

[48] Cal. Dep't of Developmental Services, *Services Provided by Regional Centers*, https://www.dds.ca.gov/RC/RCSvs.cfm.

[49] Cal. Dep't of Developmental Services, *Respite (In-Home) Services*, https://www.dds.ca.gov/SupportSvcs/Respite.cfm.

programs, and other services.[50] Additionally, States' Medicaid programs can provide home and community-based services for persons with developmental disabilities.[51] These services, which include access to skilled nurses, chore services, vehicle adaptations, and therapy,[52] assist those living with developmental disabilities, including Down syndrome, to lead independent, productive lives. *See Ball v. Kasich*, 307 F. Supp. 3d 701, 707-708 (S.D. Ohio 2018) (noting that States' shifts in focus and funding toward community-based services have led to increased

[50] Conn. Gen. Stat. §§ 17a-217, 17a-218, 17a-219b, 17a-221 *et seq.*, 17a-226.

[51] *See, e.g.*, Cal. Dep't of Health Care Services, *Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD)*, Medi-Cal, http://www.dhcs.ca.gov/services/medi-cal/Pages/HCBSDDMediCalWaiver.aspx; Massachusetts Dep't of Developmental Services in Massachusetts: https://www.mass.gov/orgs/department-of-developmental-services; N.M. Stat. Ann. § 28-16A-1 *et seq*. (charging the Department of Health to establish a Developmental Disabilities Planning Counsel to oversee provision of community-based services for people with developmental disabilities); N.Y. Dep't of Health, *Homes and Community-Based Services (HCBS) Waiver for Persons, Including Children, with Mental Retardation and/or Developmental Disabilities*, https://www.healthy.ny.gov/publications/0548/hcbs_mental_ retardation_dev_disabilities.htm; Pa. Dep't Human Servs., *Pennsylvania's Medicaid Waivers for Intellectual Disabilities Supports and Services*,http://www.dhs.pa.gov/learnaboutdhs/waiverinformation/medicaidwaivers forintellectualdisabilitiessupportsandservices; Wash. State Dep't of Social and Health Services, Developmental Disabilities Admin., https://www.dshs.wa.gov/dda.

[52] *Id*; *see also* N.J.S.A. § 30:6D-12.1 *et seq*. (providing self-directed support services for persons with developmental disabilities).

satisfaction among individuals with intellectual and developmental disabilities and their families).[53]

Many States provide additional services and support specifically for new or expectant parents of a disabled child. For example, Massachusetts' Down syndrome Congress is a statewide resource for Down syndrome information, advocacy, and networking.[54] In addition to free resources, information and training for potential parents, health professionals, educators and the community at large, it also offers the "Parents' First Call Program," which connects new or expectant parents with a diagnosis of Down syndrome with others who have had similar life experiences.

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[53] The suggestion that availability of abortion care will lead to reduced research and treatment for individuals with Down syndrome is likewise a red herring. For example, California also chooses in invest in research regarding treatment of Down syndrome through the UC San Diego School of Medicine's Down Syndrome Center for Research and Treatment—"one of the first programs in the country to connect academic research with treatment of adults and children with Down syndrome." *See* Down Syndrome Center for Research and Treatment, *About Us*, UC San Diego School of Medicine, https://neurosciences.ucsd.edu/centers/down-syndrome-center/about/Pages/default.aspx.

[54] Commonwealth of Mass., Understand Your Pediatric Patient's Down Syndrome Diagnosis, https://www.mass.gov/info-details/understand-your-pediatric-patients-down-syndrome-diagnosis; *see also* Wash. State Dep't of Health, *Down Syndrome: Information for Parents Who Have Received a Pre- or Postnatal Diagnosis of Down Syndrome*, https://www.doh.wa.gov/YouandYourFamily/InfantsandChildren/HealthandSafety/GeneticServices/DownSyndrome.

The efforts described above are just some of the ways States can protect and improve the lives of persons with developmental disabilities, dispel outdated stereotypes and discrimination, and support families with disabled children, without infringing on reproductive rights.

B. Eliminating Disability Discrimination and Stereotypes and Protecting Women's Access to Reproductive Healthcare Are Complementary Objectives

Eliminating outdated views about disability and protecting women in need of reproductive healthcare share important principles. Both rest on the "universal human rights principles of bodily autonomy, self-determination, equality and inclusion."[55] Both seek to remove barriers to full participation in society and to challenge structural inequalities. *Id.* There is thus no conflict between these objectives.

Amici States share Arkansas's goal of protecting the autonomy and dignity of individuals living with developmental disabilities, eliminating outdated information about what it means to live with a developmental disability, providing support to families raising children with such disabilities, and ensuring that adults living with such disabilities are valued and included in society. But using the law

[55] Ctr. for Reproductive Rights, *Shifting the Frame on Disability Rights for the U.S. Reproductive Rights Movement* 5 (2017), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Disability-Briefing-Paper-FINAL.pdf.

to "force women to bear children with disabilities (when they do not want to do so) will fail to solve . . . broader stigma, and may even be counterproductive."[56] These concerns were echoed by amici in *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, where a number of disability rights leaders joined an amicus brief opposing the Indiana law that closely resembled the law in this case.[57] They rejected the argument that state abortion bans are ethically necessary, arguing instead that ensuring the right to choose "empowers women and families who make the affirmative choice to see a pregnancy through to term" and "provides the greatest assurance that the mother and her family will be able to create and maintain an environment in which a disabled child is likely to thrive."[58]

Valuing and respecting the contribution of individuals with disabilities, and respecting the rights of women to choose to terminate pre-viability pregnancies complement, rather than undermine, each other. This Court should reject Arkansas's attempt to roll back the clock, denying respect for women and their

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[56] Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 Harv. J. of L & Gender 424, 441, 457-58 (2006) (noting that "the most vocal disability-rights critics of prenatal testing and selective abortion do not even urge that those practices be subject to legal regulation. . . .").

[57] Amicus Br. for Disability Advocates Supporting Plaintiffs-Appellees, *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, No. 17-3163, 2018 WL 378975 (7th Cir. Jan. 3, 2018).

[58] *Id.* at 4.

reproductive choices while failing to advance the dignity and inclusion of persons with disabilities.

CONCLUSION

The district court's judgment should be affirmed.

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Respectfully submitted,

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Certificate of Compliance

This foregoing brief complies with the limitations in Rule 29, 32(a)(5), 32(a)(6), and 32(a)(7)(B) and the brief contains 6,399 words. The undersigned certifies that the electronically filed brief has been scanned for viruses and is virus-free.

Dated: January 7, 2020 */s Karli Eisenberg*

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I certify that on January 7, 2020, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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