IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

REPRODUCTIVE HEALTH SERVICES OF PLANNED PARENTHOOD OF THE ST. LOUIS REGION, ET AL.,
PLAINTIFFS-APPELLEES,

V.

GOVERNOR MICHAEL L. PARSON, ET AL.,
DEFENDANTS-APPELLANTS.

On Appeal from the United States District Court
for the Western District of Missouri
No. 2:19-cv-4155-HFS
Hon. Howard F. Sachs, Judge

BRIEF FOR AMICI CURIAE STATES OF CALIFORNIA, ILLINOIS, COLORADO, CONNECTICUT, DELAWARE, HAWAIʻI, 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

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.). In May 2019, Missouri passed House Bill 126, which makes it a crime to perform an abortion at or after 8, 14, 18, or 20 weeks of pregnancy ("Gestational Age Bans")—despite the fact that viability does not occur until well after the last of these gestational limits. ADD1, 6.[1] Missouri also passed a law ("Reason Ban") prohibiting abortions where the pregnant woman's sole reason for terminating a pregnancy is based on a "prenatal diagnosis, test, or screening" indicating Down syndrome or the potential for it. ADD1. Because these Bans prohibit women from exercising their right to obtain an abortion before viability, they are unconstitutional under the law. *Casey*, 505 U.S. at 860. Amici States California, Illinois, Colorado, Connecticut, Delaware, Hawai'i, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and the District of

[1] As the district court explained, the "cascading" "Gestational Age Bans" initially prohibit "abortions after 8 weeks from the patient's last menstrual period. If this is deemed constitutionally forbidden, the weeks are extended to 14, then 18, and finally 20." ADD6.

Columbia support plaintiffs-appellees in overturning the Bans and support access to pre-viability abortion.[2]

Missouri's Bans threaten amici States' residents and amici States' healthcare systems. Residents of amici States may need access to reproductive healthcare while visiting, studying, or working in Missouri, and physicians licensed in amici States practice medicine in Missouri. JA133, JA149 (reflecting that Illinois physician practices in Missouri); JA101, JA102 (same). Amici States are also concerned that Missouri's restrictive abortion laws will cause Missourians to seek abortion care in amici States, thereby straining their healthcare systems. *See Norton v. Ashcroft*, 298 F.3d 547, 558 (6th Cir. 2002) (citing Congressional findings that "patients must often travel interstate to obtain reproductive health services"). Indeed, historically, more Missourians travel to Illinois for abortions when Missouri makes it harder to access abortions. Such an influx in patients imposes additional demands on Illinois's healthcare system.

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. 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 they have promoted women's health, which

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

demonstrate that protecting women's constitutionally guaranteed right to abortion access is integral to advancing women's health.

Amici States are also committed to 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—in a manner consistent with the States' constitutional obligation to protect women's reproductive rights.

ARGUMENT

I. MISSOURI'S 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. *See 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, 2320 (2016); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772-73, 776 (8th Cir. 2015) (striking

down a 6-week ban); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (per curiam) (holding 12-week abortion ban unconstitutional).[3]

Missouri's Bans are contrary to this controlling precedent. With narrow exceptions, the Gestational Age Bans prohibit women in Missouri from obtaining an abortion for several weeks before viability. *MKB Mgmt. Corp.*, 795 F.3d at 773 (viability is at "about 24 weeks"). Likewise, the Reason Ban prohibits women from obtaining abortions at any point prior to viability, if the woman's choice is based on reasons disfavored by Missouri lawmakers. The district court correctly held that no state interest can justify a ban on abortion prior to viability. ADD3-7. 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

Missouri asserts that its Gestational Age Bans are aimed, in part, at protecting maternal health. Appellants' Opening Brief (AOB) at 45. But those Bans do not serve that purpose. The best way to advance women's health is to provide meaningful access to a comprehensive range of reproductive healthcare services,

[3] *See also Jackson Women's Health Organization v. Dobbs*, 945 F.3d 265, 271-274 (5th Cir. 2019) (15-week abortion ban unconstitutional); *Isaacson v. Horne*, 716 F.3d 1213, 1222-23, 1231 (9th Cir. 2013) (20-week ban unconstitutional); *Jane L.* v. *Bangerter*, 102 F.3d 1112, 1114, 1117-18 (10th Cir. 1996) (22-week (equivalent) ban unconstitutional).

including abortion.[4] The American Medical Association (AMA) and 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 Missouri's) lead to *worse* health outcomes and do not lower abortion rates.[6] Moreover, there is a direct connection between restrictive abortion laws and *higher* maternal mortality rates.[7] As the experience of amici States

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

[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 Induced Abortion Worldwide*, Guttmacher Inst., 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*, 26 Women's Health Issues 55 (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 19:1 at 5, 8 (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0705-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).

demonstrates, States have a range of options to promote women's healthcare that do not restrict 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 a wide array of negative health consequences. 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 obtain abortions.[8] Women who have pregnancies too close together face an increased risk of premature birth, low birth weight, congenital disorders, and schizophrenia.[9] Carrying an unwanted pregnancy to term can also result in a greater risk of domestic violence.[10]

In particular, the health of Illinois residents is at risk under Missouri's Bans because many residents of southern Illinois—which borders Missouri—are

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[8] Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women's Health Issues 55, 58 (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.

[10] Sarah C.M. Roberts, et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12:144 BMC Medicine at 5 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182793/.

transferred to Missouri hospitals for high-risk care when it is unavailable in Illinois hospitals. If these Illinoisans face maternal safety concerns or prenatal complications, the closest hospital that can treat them might be in Missouri, where they will be subject to the Bans. In fact, the Illinois Department of Public Health issued a grant to a Missouri hospital for the Southern Illinois Perinatal Network that provides maternal and neonatal transport services and treats high-risk perinatal patients.[11] Under the Bans, more Illinois patients transferred to these Missouri hospitals will be unable to obtain needed reproductive care.

Lack of access to abortion also results in poorer socioeconomic outcomes, including lower rates of full-time employment and increased reliance on public programs.[12] Conversely, increased availability of abortion results in *increased* women's participation in the workforce, especially for women of color.[13] As the

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[11] *Designation Allows Better High-Risk Mom and Baby Care in IL*, Barnes-Jewish Hospital (2010), https://www.barnesjewish.org/Newsroom/Publications/Innovate/Winter-2010/Designation-Allows-Better-High-Risk-Mom-and-Baby-Care-in-IL; *Southern Illinois Perinatal Network (SPIN)*, St. Louis Children's Hospital, https://www.stlouischildrens.org/conditions-treatments/women-infants-center/newborn-medicine/admission; Ill. Admin. Code tit. 77, § 640.44.

[12] Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, 103 Am. J. Pub. Health 407, 409 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/.

[13] *See* Anna Bernstein, et al., *The Economic Effects of Abortion Access: A Review of the Evidence*, Ctr. for Economics of Reproductive Health, Institute for Women's

Supreme Court recognized, women's control of their reproductive healthcare ensures that they can participate "equally in the economic and social life of the Nation." *Casey*, 505 U.S. at 856; *see also Priests for Life v. U.S. Dep't of Health and Human Services*, 808 F.3d 1, 22-23 (2015) (Kavanaugh, J., dissenting) ("It is commonly accepted that reducing the number of unintended pregnancies would further women's health, advance women's personal and professional opportunities, reduce the number of abortions, and help break a cycle of poverty.").

When States shorten the time in which women may exercise their right to obtain an abortion, these issues are exacerbated.[14] Many women will not even realize they are pregnant early enough to seek out abortion services, especially if Missouri's 8-week Gestational Ban takes effect.[15] Moreover, the 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

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Policy Research (2019), at v., https://iwpr.org/wp-content/uploads/2019/07/B379_Abortion-Access_rfinal.pdf.

[14] The effects of Missouri's Gestational Age Bans and Reason Ban are amplified by Missouri's other obstacles to obtaining an abortion, such as (1) a mandatory 72-hour waiting period, requiring that women make two separate trips to the clinic at least three days apart before obtaining an abortion, (2) the same-doctor requirement, which makes scheduled two visits more challenging, and (3) a prohibition that precludes public insurance from covering abortion in nearly all circumstances. Mo. Rv. Stat. § 376.805.

[15] *See* JA111, JA110.

factors including cost and access barriers.[16] 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."[17] It is these women who will suffer as a result of the unconstitutional abortion restrictions like the Bans.[18] Women who learn of fetal anomalies or develop complications relating to their own health during pregnancy would also be disproportionately affected by Missouri's Gestational Age Bans as many of these developments are detected during the second trimester.[19]

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[16] Lawrence B. Finer, et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 341 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/10/17/Contraception74-4-334_Finer.pdf.

[17] 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/.

[18] 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 Second-Trimester Abortions*, PLOS ONE, 12(1), 1 (2017), http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169969.

[19] Boaz Weisz, et al., *Early Detection of Fetal Structural Abnormalities*, 10 Reproductive BioMedicine Online 541 (2005), https://doi.org/10.1016/S1472-6483(10)60832-2.

Moreover, it is already difficult to access abortion in much of the country, including Missouri, which has only one clinic that provides abortions.[20] Although it is a "common medical procedure," many large cities do not have any clinics that offer abortions.[21] Women in 27 major U.S. cities have to travel more than 100 miles to reach an abortion facility.[22] In 2014, women in Missouri had to travel a median distance of 36.99 miles to obtain an abortion.[23] Such extensive travel for abortions is especially burdensome for those who rely on public transit, lack disposable income, or provide care to children or other dependents. 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 5 states had only 1 clinic.[24] In Missouri, 97%

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[20] JA26.

[21] 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/.

[22] *Id*.

[23] *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.

[24] 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.

of counties have no clinic that provides abortion and 78% of Missouri women live in those counties.[25]

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.[26] *See Whole Woman's Health*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, at great risk to their health and safety.").

In addition to introducing undue hardship on the patients seeking care, these healthcare deserts—which are the result of restrictive laws like Missouri's—lead women to seek out abortion services from neighboring States. This influx of out-of-state patients places additional pressure on state regulators to monitor the services provided. To address increased demand, abortion clinics will often hire additional physicians or construct new facilities. But it is not always possible for clinics to accept new patients. As the Seventh Circuit has recognized, an

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[25] *Id*. at 17.

[26] 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.

expansion of "staff and facilities to accommodate such an influx . . . would be costly and could even be impossible given the difficulty of recruiting abortion doctors." *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015). And when clinics cannot satisfy the increased demand, patients may be unable to obtain needed abortion care. *Id.*

Historically, more Missourians come to Illinois for abortions when Missouri makes it harder for its citizens to access abortions. This trend traces back to October 2014, when a Missouri law increased the waiting period before an abortion procedure from 24 to 72 hours. Mo. Ann. Stat. § 188.027. Indeed, the number of Missourians who received abortions in Illinois jumped from 712 patients in 2014 to 1,035 patients in 2015, and continued to increase to 1,663 patients in 2016.[27] In 2017, out-of-state residents accounted for about 14% of abortions in Illinois, double the percentage in 2012.[28] By 2019, one Illinois abortion clinic near Missouri border reported that almost half of its patients are

[27] *Abortions Distributed by State of Maternal Residence and State of Clinical Service*, Div. of Reproductive Health, Nat'l Ctr. for Chronic Disease Prevention and Health Promotion (2014-16), https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.

[28] *Supra* note 25; *see also 2017 Illinois Abortion Statistics*, Ill. Dep't of Pub. Health (2017), http://www.dph.illinois.gov/data-statistics/vital-statistics/abortion-statistics.

from Missouri—a 30% increase since 2017.[29] Nor is this impact limited to Illinois; about half of all abortions performed in Kansas in 2018 were for Missouri residents.[30] Should Missouri's Bans take effect, it is reasonable to assume that Missourians seeking abortions will travel to Illinois, Kansas, and other neighboring States.

Finally, the States' interest in promoting access to safe abortion care is underscored here, as many of the amici States' residents attend universities located in Missouri.[31] Although these students may have temporarily left the amici States to pursue their education, the States retain an interest in ensuring that they are spared the stress, anxiety, and financial hardship associated with not having access to constitutionally protected medical care.

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[29] Sabrina Tavernise, *New Illinois Abortion Clinic Anticipates Post-Roe World*, N.Y. Times, at A12 (Oct. 22, 2019).

[30] *Abortions in Kansas, 2018*, Kan. Dep't of Health & Env't, at 5, 7 (Apr. 2019), http://www.kdheks.gov/phi/abortion_sum/2018_Preliminary_Abortion_Report.pdf; Hannah Haksgaard, *Rural Women & Developments in the Undue Burden Analysis*, 65 Drake L. Rev. 663, 709 (2017); *see also*, *e.g.*, *EMW Women's Surgical Ctr.. P.S.C. v. Glisson*, 2018 WL 6444391, at *9 (W.D. Ky. Sept. 28, 2018) ("Because Kentucky permitted later-term abortions compared to other states . . . , residents of the neighboring states of Indiana, Ohio, Tennessee, and West Virginia have traveled to [Kentucky] to have an abortion.").

[31] *Student Body Profile, Fall 2017*, University of Missouri (Nov. 1, 2017), https://enrollment.missouri.edu/wp-content/uploads/2017/02/Fall-2017.pdf. (4,813 of 30,870 students at University of Missouri come from Illinois)

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

Amici States agree with Missouri that States have an essential role to play in protecting and improving the health of women. 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 Woman's Health*, 136 S. Ct. at 2309-2318; *Gonzales*, 550 U.S. at 165. And that is especially true where, as here, a law clearly contravenes Supreme Court precedent. *See supra* at 3-4; *Gonzales*, 550 U.S. at 165.

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, an Illinois program provides high-quality pregnancy planning services to low-income individuals, thereby lowering the incidence of unintended pregnancies and sexually transmitted diseases; providing HIV testing and counselling; and offering teen clinics.[32] Similarly, a Maryland

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

program funds home visits to address prenatal care, infant mortality, childhood immunizations, child abuse and neglect, and school readiness.[33] Maryland also provides educational training to hospital maternity staff.[34] *See also* Amicus Br. for State of California et al., *Jackson Women's Health Org. v. Dobbs*, No. 19-60455, 2019 WL 5099416, at *9-34 (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 pregnancies and reduces the abortion rate."[35] 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.

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

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

[35] 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); *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.

Code § 31-3834.03, while others require such coverage for those plans that require prescription coverage, *see* 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 programs for teens, including comprehensive sex education and adult-teen communication programs. Similarly, a New York program provides low-income individuals and communities of color access to family planning care.[36] In 2017, 21.5% of the program's female clients 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).[37]

With these measures, amici States have made significant strides in reducing maternal mortality rates.[38] The United States has the highest rate of maternal

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[36] *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/.

[37] Lauren Tobias Decl., *State of Oregon v. Azar*, Dist. Ct. of Oregon, No. 19-cv-00317, Dkt. No. 66, at 7 (March 21, 2019).

[38] *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

mortality in the developed world, and Missouri has one of the highest rates of maternal mortality in the country.[39] Nationally, more than 700 women die of pregnancy-related complications and more than 50,000 women experience a life-threatening complication every year.[40] While the majority of countries 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.[41] Compared to women in Canada and the United Kingdom, women

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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/.

[39] 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-developed-world; Jessica Engel, et al., *Maternal Mortality in Missouri: A Review of Challenges and State Policy Options*, Ctr. for Health Economics and Policy, Inst. for Public Health at Washington Univ. (Oct. 2019), https://publichealth.wustl.edu/wp-content/uploads/2019/10/Maternal-Mortality-in-Missouri-Final-oct-30.pdf ("Missouri ranked 44th in the U.S. for maternal mortality in 2019").

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

[41] *Id*. Many of the states with the highest maternal death rates are states with restrictive abortion laws. *See* Maternal Mortality, America's Health Rankings, United Health Found. (2018),

in the United States are over three times more likely to die from complications relating to childbirth.[42] These alarming numbers prompted Congress to pass the bipartisan Preventing Maternal Deaths Act of 2017.[43] Similarly, several amici States took prompt action by enacting legislation to promote women's health and curb this distributing trend. For instance, California initiated a multi-stakeholder organization committed to ending preventable morbidity, mortality, and racial disparities in California's maternity care.[44] And these efforts have borne fruit. California saw maternal mortality decline by 57% between 2006 to 2013, from

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https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/ALL.

[42] Lu, *supra* note 40. 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/.

[43] *Preventing Maternal Deaths Act 2018*, Pub. L. No. 115-344, 132 Stat. 5047, https://www.congress.gov/bill/115th-congress/house-bill/1318?s=1&r=2.

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

16.9 to 7.3 deaths per 100,000 live births.[45] Among the 50 states, maternal mortality is the lowest in California.[46]

In amici States' experience, policies that support the health of women, including abortion access, also benefit the health of their future children. *Cf.* AOB at 44-46. Abortion access results in reduced unintended births, and when children are planned, they have improved educational and economic outcomes both during childhood and later in life.[47] Additionally, 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 effectively promote women's health without infringing on women's constitutional right to access abortion services.

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[45] *Pregnancy Associated Mortality Review*, Cal. Dep't of Pub. Health (Apr. 2018) https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Communications/Profile-PAMR.pdf.

[46] *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.

[47] Bernstein, *supra* note 13.

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 Missouri 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 Missouri's "Reason Ban," which unlawfully interferes with reproductive autonomy. ADD3-6; *see also Planned Parenthood of Ind. and Ky., Inc. v. Comm'r of Ind. 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 Ind. & Ky., 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 Missouri 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 Missouri suggests. AOB at 29-30, 35. States can and do promote the provision of medically accurate, unbiased information in order to help women make informed reproductive choices. States can also provide (and publicize) civil rights protections and social and medical services, and support those living with developmental disabilities and their families. These efforts combat discrimination, reduce bias among doctors and patients, and protect individuals with Down syndrome and their families without infringing on women's reproductive autonomy.

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 2008, 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(b)(1)(B)(ii).

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 National Down Syndrome Society (NDSS), the "leading human rights organization for all individuals with Down Syndrome," did not support Missouri's Reason Ban.[48] Rather, NDSS supports pro-information laws, ensuring that women

[48] National Down Syndrome Society, https://www.ndss.org/our-story/mission/; *see also* Sarah McCammon, *Down Syndrome Families Divided over Abortion Ban*, Nat'l Public Radio (Dec. 13, 2017) https://www.npr.org/2017/12/13/570173685/down-syndrome-families-divided-over-abortion-ban (explaining that the National Down Syndrome Congress "isn't taking a position" on the Reason Ban).

and their families receive the most accurate, up-to-date information. NDSS explains that as a threshold matter, the decision "[w]hether to undergo prenatal testing must be solely that of the pregnant woman."[49] But once a woman decides to undergo prenatal testing, that testing "should be made available to any pregnant woman" because "[k]nowing in advance either the risk or diagnosis of Down syndrome can help parents educate, inform and prepare themselves for all issues regarding this genetic condition."[50] Furthermore, "[i]t is important that [families] receive accurate information and understand all [] options."[51] 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

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[49] *NDSS Position Statement on Prenatal Testing*, https://www.ndss.org/wp-content/uploads/2018/06/NDSS-Position-Statement-on-Prenatal-Testing.pdf; *see also A Promising Future Together: A Guide for New and Expectant Parents*, National Down Syndrome Society, at 7 (2015), https://ardownsyndrome.org/wp-content/uploads/2018/02/NDSS-NPP-English.pdf; JA669 ("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").

[50] *NDSS Position Statement on Prenatal Testing*, https://www.ndss.org/wp-content/uploads/2018/06/NDSS-Position-Statement-on-Prenatal-Testing.pdf.

[51] *A Promising Future Together: A Guide for New and Expectant Parents*, National Down Syndrome Society, at 7 (2015), https://ardownsyndrome.org/wp-content/uploads/2018/02/NDSS-NPP-English.pdf.

long waiting list of families in the United States ready to adopt a child with Down syndrome," while other parents may "discontinue their pregnancy."[52]

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 Rehabilitation Act, 29 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.[53] Passage of the landmark

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[52] *Id*.; *see also NDSS Position Statement on Prenatal Testing*, https://www.ndss.org/wp-content/uploads/2018/06/NDSS-Position-Statement-on-Prenatal-Testing.pdf (after diagnostic testing, "[a]ll women, regardless of age, reproductive history or disability statutes, must be given the absolute right to continue a pregnancy").

[53] *See, e.g*., Cal. Gov't Code §§ 12940, 12955 (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.1112 (protecting persons with developmental disabilities from employment

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."[54]

Furthermore, States can reduce bias and support individuals with Down syndrome and their families by offering supportive medical and social services to persons with disabilities. These types of services "make it possible to meet the needs of families raising children, including children with disabilities."[55] 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.[56] These centers also provide in-home respite care, non-medical care that relieves families

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discrimination); 43 Pa. Stat. §§ 951-63; Va. Code §§ 51.5-1, 51.5 (setting forth state policy and rights of individuals with disabilities).

[54] *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*, Nat'l Council on Disabilities, at 10 (2012), https://www.ncd.gov/rawmedia_repository/NCD_Paradigms_Mar26FIN.pdf.crdownload.pdf.

[55] Sujatha Jesudason & Julia Epstein, The Paradox of Disability in Abortion Debates: Bringing the Pro-Choice and Disability Rights Communities Together, 84 Contraception 541, 541-43 (2011).

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

from providing constant care to a loved one with a developmental disability.[57] 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 programs, and other services.[58] Additionally, States' Medicaid programs can provide home and community-based services for persons with developmental disabilities.[59] These

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

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

[59] *See, e.g.*, *Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD)*, Cal. Dep't of Health Care Services, 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); *Homes and Community-Based Services (HCBS) Waiver for Persons, Including Children, with Mental Retardation and/or Developmental Disabilities*, N.Y. Dep't of Health, https://www.health.ny.gov/publications/0548/hcbs_mental_retardation_dev_disabilities.htm; *Pennsylvania's Medicaid Waivers for Intellectual Disabilities Supports and Services*, Pa. Dep't Human Servs., https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/Services-for-Persons-with-Disabilities.aspx; Wash. State Dep't of Social and Health Services, Developmental Disabilities Admin., https://www.dshs.wa.gov/dda.

services, which include access to skilled nurses, chore services, vehicle adaptations, and therapy,[60] 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 satisfaction among individuals with intellectual and developmental disabilities and their families).[61]

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.[62] In addition to free resources, information and

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

[61] The suggestion that the availability of abortion will lead to reduced research and treatment for individuals with Down syndrome (AOB at 33) is a red herring. For example, California also chooses to 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 About Us*, Down Syndrome Center for Research and Treatment, UC San Diego School of Medicine, https://neurosciences.ucsd.edu/centers/down-syndrome-center/about/Pages/default.aspx.

[62] *Understand Your Pediatric Patient's Down Syndrome Diagnosis,* Commonwealth of Mass., https://www.mass.gov/info-details/understand-your-pediatric-patients-down-syndrome-diagnosis; *see also Down Syndrome: Information for Parents Who Have Received a Pre- or Postnatal Diagnosis of*

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.

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. None of these efforts require infringement 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."[63] Both seek to remove barriers to full participation in society and to

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Down Syndrome, Wash. State Dep't of Health, https://www.doh.wa.gov/YouandYourFamily/InfantsandChildren/HealthandSafety/GeneticServices/DownSyndrome.

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

challenge structural inequalities. *Id.* There is thus no conflict between these objectives.

Amici States share Missouri'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 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."[64] 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.[65] 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

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[64] Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 Harv. J. of L & Gender 424, 441, 457-58 (2006).

[65] 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).

"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."[66]

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 Missouri's attempt to roll back the clock, denying respect for women and their reproductive choices while failing to advance the dignity and inclusion of persons with disabilities.

CONCLUSION

The district court's judgment should be affirmed.

[66] *Id.* at *4.

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This foregoing brief complies with the limitations in Fed. R. App. P. 29 and 32(a)(7)(B) and the brief contains 6,406 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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