April 12, 2019

ATTORNEY GENERAL KWAME RAOUL FILES AMICUS BRIEF TO PROTECT WOMEN'S REPRODUCTIVE RIGHTS

Chicago — Attorney General Kwame Raoul, as part of a coalition of 22 attorneys general, today filed a brief in the U.S. Court of Appeals for the 5th Circuit, supporting Mississippi's last abortion clinic in Jackson Women's Health Organization, et al. v. State Health Officer of the Mississippi Department of Health, et al. The case challenges Mississippi House Bill 1510, which prohibits doctors from providing abortion services past 15 weeks.

The amicus brief filed today by Raoul and the coalition argues that state laws cannot prohibit a woman from her constitutionally protected right to terminate her pregnancy before viability under Roe v. Wade. Raoul and the attorneys general argue the banning of abortions after 15 weeks flatly forbids women from exercising their right to choose pre-viability abortion.

"A woman's reproductive decisions are deeply personal and should be made solely by her, her partner, and her health care provider," Raoul said. "I will continue to work with my counterparts in other states to protect a woman's right to control her health care."

In March 2018, Mississippi enacted House Bill 1510. House Bill 1510 places a ban on abortion services after the 15th week of pregnancy. The Jackson Women's Health Organization, the sole abortion provider in Mississippi, filed suit challenging the ban and requesting a temporary restraining order. The defendants are the state officers responsible for overseeing public health. On Nov. 20, 2018, the district court granted summary judgment for the plaintiffs and issued a permanent injunction. The court held that the proposed state law violated women's right to due process under the 14th Amendment.

Joining Attorney General Raoul in filing the brief are the attorneys general of California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington.

No. 18-60868

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

JACKSON WOMEN'S HEALTH ORGANIZATION, ON BEHALF OF ITSELF AND ITS PATIENTS; SACHEEN CARR-ELLIS, M.D., M.P.H., ON BEHALF OF HERSELF AND HER PATIENTS,

Plaintiffs-Appellees,

v.

THOMAS E. DOBBS, M.D., M.P.H., IN HIS OFFICIAL CAPACITY AS STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH; KENNETH CLEVELAND, M.D., IN HIS OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE,

Defendants-Appellants,

On Appeal from the United States District Court
for the Southern District of Mississippi

BRIEF FOR AMICI CURIAE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAI'I, ILLINOIS, IOWA, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, 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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CERTIFICATE OF INTERESTED PERSONS

Because the Amici States are governmental entities, a certification of interested persons is not required. 5th Cir. R. 28.2.1.

Date: April 12, 2019 *s/Karli Eisenberg*______________

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INTERESTS OF AMICI CURIAE

Through the statute at issue in this appeal, Mississippi has banned abortions that occur after 15 weeks' gestation (with the narrowest of exceptions), justifying the prohibition as protecting women's health.[1] Because Mississippi's law prohibits women from exercising their right to obtain an abortion before viability (about 24 weeks), it is plainly unconstitutional. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (plurality op.). Amici States California, Colorado, Connecticut, Delaware, Hawai'i, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia support plaintiffs-appellees in overturning the ban and, more generally, support access to abortion and contraceptives, which give women the ability to participate equally in the economic and social life of the Nation and to maintain control over their reproductive lives. *Id*. at 856.[2]

Amici States recognize and share Mississippi's interests in protecting the health of all women, including women of childbearing age. But reducing or

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[1] The statute measures gestational age by "the time that has elapsed since the first day of the woman's last menstrual period." *Jackson Women's Health Organization v. Currier*, 349 F.Supp.3d 536, 538 n.1 (S.D. Miss. 2018). And under the statute, a medical emergency exists only when necessary to save the woman's life or because the woman is facing "a serious risk of substantial and irreversible impairment of a major bodily function." *Id*. at 538.

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

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 by expanding access to healthcare services and contraceptives, supporting maternal and infant health care programs, offering educational and counselling services, and 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.

ARGUMENT

I. MISSISSIPPI'S PROHIBITION OF PRE-VIABILITY ABORTION IS UNCONSTITUTIONAL

Nearly half a century ago, the Supreme Court concluded 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. And in the years that followed, the Court has 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); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016).[3]

The law at issue in this appeal ignores this controlling precedent. With only a few narrow exceptions, it prohibits women in Mississippi from seeking abortions after a 15-week gestational period—thus prohibiting them from getting an abortion for up to nine weeks before viability. *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (viability now occurs at "about 24 weeks"); *see also Casey*, 505 U.S. at 860 (viability occurs "at 23 to 24 weeks."). The district court correctly held that no state interest can justify a ban on abortion prior to viability. *Jackson Women's Health Organization*, 349 F.Supp.3d at 541. This Court should affirm on that basis.

II. STATES' INTEREST IN PROMOTING WOMEN'S HEALTH IS SERVED BY ENSURING ACCESS TO ABORTION

Mississippi asserts that its ban on abortions after 15 weeks is aimed at "'protecting the health of women.'" AOB 30. However, it is well established that the best way to advance women's health is to provide meaningful access to a

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[3] *See also Sojourner T. v. Edwards*, 974 F.2d 27, 30 (5th Cir. 1992) ("a State's interests are not strong enough to support a prohibition of abortion"); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (holding 12-week abortion ban unconstitutional); *Isaacson v. Horne*, 716 F.3d 1213, 1222-23 (9th Cir. 2013) (holding 20-week ban unconstitutional because viability is the "critical point" of inquiry).

comprehensive range of reproductive health care services.[4] Safe, legal abortion is an important component of that care; indeed, overwhelming scientific evidence establishes that highly restrictive abortion laws (like the one at issue here) lead to *worse* health outcomes for women, while failing to lower abortion rates.[5] And if the State's goal is to reduce the number of abortions, increasing access to effective contraception "dramatically reduces unwanted pregnancies and reduces the abortion rate."[6] Indeed, "[c]ontraceptive use is a *key predictor* of whether a woman will have an abortion. In 2011, the very small group of American women

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[4] Position Paper, Am. College of Physicians, *Women's Health Policy in the United States*, Ann. Intern. Med. 2018; 168(12) at 876-77 (describing the importance of integrated reproductive health care, which includes family planning, disease screening, contraception, prenatal care, and pregnancy termination).

[5] *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. The abortion rate is 37 per 1,000 women in countries that prohibit abortion altogether or allow it only to save a woman's life, and 34 per 1,000 in countries that allow abortion without restriction as to reason—a difference that is not significant."); 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.

[6] 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).

who were at risk of experiencing an unintended pregnancy but were not using contraceptives accounted for the majority of abortions."[7]

Barriers to abortion access lead to negative health and socioeconomic consequences for women who are forced to delay or forgo a wanted abortion. Women who are forced to carry an unwanted pregnancy to term risk negative side effects such as postpartum hemorrhage and eclampsia, and report a need to limit physical activity for a period of three times longer than women who receive abortions.[8] Additionally, carrying an unwanted pregnancy to term can result in a woman remaining in contact with a violent partner and suffering physical violence.[9] Finally, lack of access to abortion results in poorer socioeconomic outcomes, including lower rates of full-time employment and increased reliance on publicly funded safety-net programs.[10]

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[7] *State Facts Abortion*, Guttmacher Inst. (May 2018), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-york. (emphasis added).

[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] 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/.

[10] 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.

When States create barriers that impede access to abortion between 15 and 24 weeks, the issues described above are compounded.[11] 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 factors including cost and access barriers.[12] 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."[13] It is these women who will suffer the most from unconstitutional abortion restrictions.[14] Women who learn of

Health 103, no. 3, at pp. 407-413 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/.

[11] For instance, Mississippi law imposes other obstacles to obtaining an abortion, including a mandatory 24-hour waiting period after receiving state-mandated information, a requirement that women make two separate trips to the abortion clinic before obtaining an abortion, a requirement that only licensed physicians perform abortions, and a ban on being prescribed abortion-inducing drugs by telephone (unlike other prescriptions). *See* Miss. Code Ann. §§ 41-75-1 *et. seq.*; *id*. § 41-41-33; *id*. 41-41-107; Miss. Admin. Code § 15-16-1:44.1.1 *et seq*. These additional restrictions are also being challenged in this lawsuit, but are not part of this appeal.

[12] 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.

[13] 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/.

[14] 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

fetal anomalies or develop complications relating to their own health during pregnancy would also be disproportionately affected by Mississippi's law, as many of these developments are first detected during the second trimester.[15]

Moreover, it is already difficult to access abortion in some parts of the country. Although it is a "common medical procedure," many large cities in the United States do not have any clinics that offer abortions.[16] Women who live in 27 major U.S. cities have to travel more than 100 miles to reach an abortion facility.[17] In 2014, about 90% of U.S. counties—home to 39% of all women between the ages of 15-44—lacked an abortion clinic, and five states had only one clinic in the

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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 (2007), http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169969.

[15] 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.

[16] 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/.

[17] *Id*. In 2014, women in Mississippi had to travel a median distance of 68.80 miles to obtain an abortion. *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.

entire state.[18] And these "abortion deserts" lead to the adverse consequences described above, including delays in care, negative mental health impacts, and consideration of self-induced abortion.[19]

III. There are Several Ways to Promote Women's Health That Do Not Limit Access to Lawful Care Options

Amici States agree with Mississippi that states have an essential role to play in protecting and improving the health of women of childbearing age. 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. *Cf. Jackson Women's Health Organization*, 349 F.Supp.3d at 540 n.22.

Many States have extended healthcare to millions of women through Medicaid expansion. The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to include childless adults with incomes up to 138% of the federal poverty line. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII),

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[18] Rachel K. Jones and Jenna Jerman, *Abortion incidence and service availability in the United States, 2014*, Perspectives on Sexual and Reproductive Health (2017), https.doi.org/10.1363/psrh.12015.

[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/; 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.

1396a(e)(14)(I)(i). And the ACA obligates the federal government to cover most of the cost of the expansion. *See* 42 U.S.C. § 1396d(y)(1) (federal government will cover 93% of cost of expansion in 2019, 90% in subsequent years). To date, 37 States and the District of Columbia, including all amici States, have expanded Medicaid, resulting in approximately 12.7 million additional Americans receiving health coverage.[20]

Amici States have also made significant strides in reducing maternal mortality rates.[21] The United States has the highest rate of maternal mortality in the developed world.[22] Every year more than 700 women die of pregnancy-related

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[20] *See Status of State Action on the Medicaid Expansion Decision*, Kaiser Family Found. (Apr. 9, 2019), https://tinyurl.com/y6uw6rhy; *see also Status of State Action on the Medicaid Expansion Decision*, Kaiser Family Found. (Feb. 13, 2019), https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[21] *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*, California 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/.

[22] 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.

complications and more than 50,000 women experience a life-threatening complication.[23] While the majority of countries worldwide are reporting declining maternal mortality rates, the numbers in the United States are on the rise. 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.[24] 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.[25] These alarming numbers prompted Congress to pass the bipartisan Preventing Maternal Deaths Act of 2017.[26]

In response to rising maternal mortality rates, the California Department of Public Health launched the California Pregnancy-Associated Mortality Review project to identify pregnancy-related deaths, causation and contributing factors, and then make recommendations to improve the quality of maternity care. In

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

[24] *Id*.

[25] *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/.

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

2006, the California Department of Public Health and Stanford University partnered to launch the California Maternal Quality Care Collaborative, a multi-stakeholder organization committed to ending preventable morbidity, mortality, and racial disparities in California's maternity care.[27] The organization utilizes a maternal data center, quality improvement initiatives, and extensive research to improve health outcomes for mothers and babies.[28] And these efforts have borne fruit. Since 2006, California has seen maternal mortality decline by 57% between 2006 to 2013, from 16.9 to 7.3 deaths per 100,000 live births.[29] Among the 50 states, maternal mortality is reported to be the lowest in California.[30]

Additional examples where amici States have improved women's health by providing access to a variety of diverse healthcare, education, and counselling services follow:

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[27] *See* California Maternal Quality Care Collaborative, https://www.cmqcc.org /who-we-are.

[28] *Id.*

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

[30] *See 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.

California

The California Department of Health Care Services (DHCS) operates a Presumptive Eligibility for Pregnant Women healthcare program which provides immediate, temporary coverage for prenatal care to low-income pregnant patients pending a formal Medicaid (known as Medi-Cal in California) application.[31] Eligible women immediately receive prenatal care and prescription drugs for conditions related to pregnancy.[32] DHCS also administers the Medi-Cal Access Program which provides uninsured, middle-income pregnant women with comprehensive health care coverage through an enrollee's post-partum period.[33] The California Department of Public Health (CDPH) administers the Black Infant Health (BIH) Program, which seeks to improve African-American infant and maternal health by using a group-based intervention strategy for improving African-American women's birth outcomes.[34] The program provides 10 prenatal and 10 post-partum group sessions addressing topics such as healthy pregnancy,

[31] *See Info. on the Presumptive Eligibility for Pregnant Women*, California Dep't of Health Care Servs., https://www.dhcs.ca.gov/ services/medical/eligibility/ Pages/PE_Info_women.aspx.

[32] *Id.*

[33] *See Medi-Cal Access Program*, California Dep't of Health Care Services, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-calAccessProgram.aspx

[34] *See Black Infant Health Program*, California Dep't of Pub. Health, https://www.cdph.ca.gov/Programs/CFH/DMCAH/ BIH/Pages/default.aspx#.

labor and delivery, and prenatal, postnatal, and newborn care in a culturally sensitive setting.[35] BIH Participants report positive outcomes.[36] And the CDPH-administered Women, Infants & Children (WIC) program provides one million Californians—pregnant and post-partum women, infants, and children under age 5—with food vouchers for nutritious foods including whole grains, protein and fruits and vegetables, nutrition education and counselling, and breastfeeding support.[37]

Connecticut

Connecticut's Family Wellness Healthy Start Initiative works to eliminate disparities in infant mortality and adverse perinatal outcomes especially among the target population of African American and Hispanic women by: (1) improving women's health; (2) promoting quality services; (3) strengthening family resilience; (4) achieving collective impact; and (5) increasing accountability

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[35] *Id.*

[36] *See SisterStory: Stories from Black Infant Health Program*, California Dep't of Pub. Health, https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Story-BIH.aspx.

[37] *See Women, Infants & Children*, California Dep't of Pub. Health, https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC/ProgramOverview.aspx.

through quality improvement, performance monitoring and evaluation.[38] Connecticut's Title V program seeks to improve Maternal and Child Health through preventive interventions.[39] And the Every Woman Connecticut Learning Collaborative implements routine pregnancy intention screening and appropriate care, education, and services to improve birth spacing and increase the likelihood of pregnancy occurring when women intend to become pregnant.[40]

Illinois

Illinois maintains a Family Planning Program that provides high-quality services to low-income individuals relating to planning pregnancies, lowering the incidence of unintended pregnancies and sexually transmitted diseases; provides HIV testing and counselling; and offers special teen clinics.[41] Illinois recently released a comprehensive Maternal Morbidity and Mortality Report that identifies

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[38] *See Healthy Start*, Connecticut 2-1-1, https://uwc.211ct.org/healthy-start/; *Hartford Has It*, Dep't of Health & Human Servs. City of Hartford, http://www.hartford.gov/hhs/maternal-child-health/ct-healthy-start.

[39] *See Guidelines for the Sexual Health Education Component of Comprehensive Health Education*, Connecticut State Dep't of Educ., https://portal.ct.gov/SDE/Publications/Sexual-Health-Education-Component-of-Comprehensive-Health-Education/Components-of-Sexual-Health-Education.

[40] *See Every Woman Connecticut*, https://www.everywomanct.org/about-the-pibo.

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

statewide trends in maternal deaths and provides recommendations to prevent maternal mortality.[42] And the Illinois Breast and Cervical Cancer Program offers free mammograms, breast exams, pelvic exams, and pap tests, as well as treatment benefits for qualifying women diagnosed with cancer.[43]

Maryland

Maryland has also implemented numerous programs to advance maternal and infant health and well-being. In 2000, Maryland established the State Maternal Mortality Review Program which: (1) identifies all maternal deaths; (2) reviews medical records and other relevant data pertaining to those deaths; (3) determines whether the deaths were preventable; (4) develops recommendations to prevent maternal deaths; and (5) disseminates its findings to policy makers, health care providers, health care facilities, and the public.[44] Maryland's Maternal, Infant, and Early Childhood Home Visiting program funds expansive home visiting programs statewide to address prenatal care, infant mortality, childhood immunizations, child

[42] *See Maternal Health*, Illinois Dep't of Pub. Health, http://dph.illinois.gov/topics-services/life-stages-populations/maternal-child-family-health-services/maternal-health.

[43] *See Illinois Breast & Cervical Cancer Program*, Illinois Dep't of Pub. Health, http://dph.illinois.gov/topics-services/life-stages-populations/womens-health-services/ibccp.

[44] *See State Maternal Mortality Review Program*, Maryland Dep't of Health, https://phpa.health.maryland.gov/mch/Pages/mmr.aspx.

abuse and neglect, and school readiness.[45] Maryland's Department of Health also provides educational training to hospital maternity staff to meet the Maryland Hospital Breastfeeding Policy Recommendations and Maryland's Baby Friendly Hospital Initiative.[46]

Massachusetts

Massachusetts has established a Maternal Mortality and Morbidity Review Committee, which is responsible for reviewing all maternal deaths within the state.[47] The Committee's mission is to study the incidence of pregnancy complications and to make recommendations to improve maternal outcomes and prevent mortality in Massachusetts.[48] Massachusetts also offers a "Welcome Family" program, which provides a one-time, free home visit by an experienced nurse to mothers with newborns to assess maternal and newborn health and well-being and to provide education, support, and referral services as needed.[49]

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

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

[47] *See Maternal Mortality and Morbidity Initiative*, Mass.gov, https://www.mass.gov/service-details/maternal-mortality-and-morbidity-initiative.

[48] *Id.*

[49] *See Welcome Family*, Mass.gov, https://www.mass.gov/welcome-family.

Massachusetts women may also access family planning and reproductive health care through the Sexual and Reproductive Health Program, which funds complete gynecological and breast exams, pregnancy testing and counselling, diagnosis and treatment of sexually transmitted diseases, emergency contraception, and birth control for uninsured and low-income residents.[50]

Michigan

The State of Michigan has developed and implemented several programs and practices to improve women's health care. Michigan has established the Michigan Maternal Mortality Surveillance program, which helps identify underlying factors associated with maternal deaths and develops policy recommendations to reduce maternal mortality and eliminate the mortality disparities in disadvantaged racial and social economic groups.[51] Michigan has convened the Maternal Infant Strategy Group to align maternal and infant health stakeholders and increase the opportunities to improve health outcomes. The State of Michigan has also implemented the Mother Infant Health and Equity Improvement Plan, which is a statewide population health plan aimed at reducing maternal and infant mortality

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[50] *See Sexual and Reproductive Health Program*, Mass.gov, https://www.mass.gov/sexual-and-reproductive-health-program-srhp.

[51] *See Michigan Maternal Mortality Surveillance Program*, Michigan Dep't of Health and Human Services, https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_87421---,00.html.

and morbidity and reducing health inequities through improving maternal health, managing pre-existing conditions, equipping providers with the resources to adequately prevent and treat obstetric emergencies, improving birth spacing, and decreasing the rate of primary cesarean section.[52]

In addition, Michigan has joined the Alliance for Innovation on Maternal Health for the purpose of implementing maternal patient safety bundles in Michigan birthing hospitals.[53] The Michigan Department of Health and Human Services Family Planning Program offers reproductive health services to Michigan women and men through a network of 31 local agencies and 92 clinics that provide services in 72 of Michigan's 83 counties.[54] And maternal home-visiting services are provided to Michigan women through the Maternal Infant Health Program, the

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[52] *See Michigan Mother Infant Health & Equity Improvement Plan*, Michigan Dep't of Health and Human Services, https://www.michigan.gov/infantmortality/0,5312,7-306-88846---,00.html

[53] *See* Alliance for Innovation on Maternal Health Program, Council on Patient Safety in Women's Health Care, https://safehealthcareforeverywoman.org/aim-program/

[54] *See generally Michigan's Family Planning Program*, Michigan Dep't of Health and Human Services, https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_6216---,00.html

Maternal Infant Early Childhood Home Visiting Initiative, and the Obstetrics Initiative.[55]

Minnesota

Minnesota's Maternal and Child Health Section provides an array of programs to improve the health status of women and their families.[56] For example, the Section operates the Family Planning Special Projects Grant Program, which funds family planning programs throughout the State of Minnesota.[57] In 2018 alone, the services provided by grantees reached 96,000 individuals through outreach activities, including providing counselling to 40,267 individuals, and providing 29,641 men and women with a range of family planning method services, with 25.6% of women choosing a "Tier 1 or most effective method."[58]

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[55] *See Maternal Infant Health Program*, Michigan Dep't of Health and Human Servs., https://www.michigan.gov/mihp/; *Michigan Home Visiting Initiative*, Michigan Dep't of Health and Human Servs., https://www.michigan.gov/homevisiting/; and Obstetric Initiatives, *Safe Births, Health Moms and Babies*, https://www.obstetricsinitiative.org/.

[56] *Maternal and Child Health Section*, Minnesota Dep't of Health, https://www.health.state.mn.us/communities/mch/index.html.

[57] *Family Planning Grant Program*, Minnesota Dep't of Health, https://www.health.state.mn.us/people/womeninfants/familyplanning/grant.html.

[58] *Family Planning Special Projects Program*, Minnesota Dep't of Health, https://www.health.state.mn.us/docs/people/womeninfants/familyplanning/grantsfs.pdf.

New York

New York has also recently determined to establish a Maternal Mortality Review Board and related recommendations from the New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes. The Executive Budget for the fiscal year that began April 1, 2019, includes an additional $8 million to fund these important initiatives over a two-year period.[59] New York has also implemented numerous programs that promote maternal and infant health and well-being. The Healthy Families New York Home Visiting Program offers home-based services to support expectant families and new parents, at no cost to the beneficiaries.[60] The New York State Department of Health's Pathways to Success Program serves over 1,000 expectant and parenting teenagers by offering educational programs, offering family-friendly events, providing childcare, and creating lactation rooms in various school districts and community colleges.[61]

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[59] Governor Cuomo Receives Report by New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, https://www.governor.ny.gov/news/governor-cuomo-receives-report-new-york-state-taskforce-maternal-mortality-and-disparate-racial; *see Maternal Mortality and Disparate Racial Outcomes*, https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf (taskforce report).

[60] *See Healthy Families New York*, https://www.healthyfamiliesnewyork.org/HomeVisits/Process.htm.

[61] *See New York State Dep't of Health – Pathways to Success*, U.S. Health and Human Servs., https://www.hhs.gov/ash/oah/grant-programs/

New York's Maternal and Infant Community Health Collaboratives initiative funds 23 locally operated programs to improve maternal and infant health outcomes for high-need, low-income women and their families.[62] And lastly, the New York State Department of Health funds 48 agencies at more than 170 sites that provide accessible, confidential reproductive health care services to women, men, and adolescents, especially low-income individuals and those without health insurance.[63] In 2016, more than 300,000 women and men received services through this state-funded family planning program, and more than 50,000 of those beneficiaries were adolescents.[64]

Pennsylvania

Pennsylvania has taken a number of steps in recent years to reduce its maternal mortality rate. The Commonwealth expanded Medicaid in 2015, and as a result more than 700,000 Pennsylvanians obtained health coverage. Last year, in response to the nationwide trend of increasing maternal mortality, Pennsylvania

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pregnancy-assistance-fund/successful-strategies/nysdoh-pathways-to-success/index.html.

[62] *See New York State Dep't of Health – Maternal and Infant Community Health Collaboratives Initiative*, https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm.

[63] *See New York State Dep't of Health – Comprehensive Family Planning and Reproductive Health Care Services Program*, https://www.health.ny.gov/community/pregnancy/family_planning/.

[64] *Id*.

enacted the "Maternal Mortality Review Act." *See* Act of May 9, 2018, P.L. 118, No. 24. Pursuant to that law, the Commonwealth convened its first-ever Maternal Mortality Review Committee, which was charged with "conduct[ing] a multidisciplinary review of maternal deaths and develop recommendations for the prevention of future maternal deaths." *Id.* § 5(a).

Vermont

Vermont maintains a Family Planning Program that provides high-quality services to low-income individuals relating to planning pregnancies, lowering the incidence of unintended pregnancies and sexually transmitted diseases, providing HIV testing and counselling, and offering services to adolescents throughout a statewide network of family planning health centers, many of them in rural communities.[65] Vermont's Title V maternal and child health block grant program, under the direction of the Department of Health's Division of Maternal and Child Health, provides leadership for clinical, community, and public health services and systems for Vermont's maternal and child population.[66] Examples of key

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[68] *See Vermont Dep't of Health – Maternal and Child Health Priorities: In Brief.* http://www.healthvermont.gov/family/reports/maternal-and-child-health-priorities-brief.

[66] *See Vermont Dep't of Health – Plans & Reports,* http://www.healthvermont.gov/family/reports; and *see HRSA – Title V Maternal and Child Health Services Block Grant Program*, https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program.

programs administered by this division include Children with Special Health Needs, reproductive health, WIC, school health, Early and Periodic Screening Diagnostic and Treatment and child preventive services, evidence-based home visiting, child injury prevention, quality improvement in clinical care and community programs, and early childhood developmental screening and support services.[67] The Division of Maternal and Child Health also administers the Personal Responsibility and Education Program, which ensures that youth throughout the state can access evidence-based teen pregnancy and sexual health programming across a network of youth serving organizations.[68] Maternal and Child Health programming also includes activities related to the primary prevention of sexual violence with an emphasis on supporting community level strategies focused on increasing knowledge and skills related to healthy relationships, health sexuality, and bystander engagement.[69]

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[67] *Vermont Dep't of Health Division of Maternal & Child Health*, Strategic Plan June 2016 – June 2018, *see* http://www.healthvermont.gov/sites/default/files/documents/2017/01/MCH%20Strategic%20Plan%2C%20Jul16%20to%20Jun18.pdf.

[68] *Id.*

[69] *See Vermont Dep't of Health – Prevent Domestic and Sexual Violence,* http://www.healthvermont.gov/children-youth-families/healthy-relationships/prevent-domestic-and-sexual-violenceermont.

Protecting women's health is a core responsibility of all States. As the amici States' policies and programs demonstrate, there are many ways States can meaningfully and effectively promote women's health without infringing on women's constitutional right to an abortion.

CONCLUSION

The district court's judgment should be affirmed.

Dated: April 12, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on April 12, 2019, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that services will be accomplished by the appellate EM/EC system.

Date: April 12, 2019 *s/Karli Eisenberg*______________

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 4,573 words, according to the count of Microsoft Word. I further certify that this brief complies with typeface and style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared in Microsoft Word using 14-point Times New Roman font.

Date: April 12, 2019 *s/Karli Eisenberg*_____________