October 4, 2019

ATTORNEY GENERAL RAOUL FILES BRIEF TO PROTECT WOMEN'S ACCESS TO REPRODUCTIVE HEALTH CARE

AG Raoul, 19 Attorneys General Argue Mississippi Abortion Law Violates Constitution

Chicago — Attorney General Kwame Raoul, as part of a coalition of 20 attorneys general, today filed an amicus brief in the United States Court of Appeals for the 5th Circuit in support of Mississippi's last abortion clinic, Jackson Women's Health Organization, in the Jackson Women's Health Organization. v. State Health Officer of the Mississippi Department of Health case.

In the brief filed in the 5th Circuit, Raoul and the attorneys general argue that a Mississippi law enacted in March, which makes it a criminal offense to perform an abortion once a heartbeat is detected, constitutes a near-complete ban on abortion. The coalition argues that the law limits the period during which a woman could receive a legal abortion to six weeks, when most women do not even know they are pregnant. Raoul and the coalition assert that the law prohibits women from exercising their constitutional right to control their reproductive health under Roe v. Wade.

"Obstructing access to safe, legal abortion does more than just infringe on women's rights to control their health care; it can also have significant health or life-threatening consequences," Raoul said. "I will continue to defend a woman's right to make her own reproductive health decisions.

Raoul and the coalition argue that contrary to Mississippi's claims, limiting or eliminating women's access to safe and legal abortion leads to worse health and socioeconomic outcomes. Outcomes include forcing women to endure negative pregnancy side effects, limited physical activity, restrictions from fulltime employment, and increased reliance on publicly-funded safety net programs. In the brief, Raoul and the coalition describe the different ways that states promote women's health without impeding women's rights upheld by the constitution.

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

No. 19-60455

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, 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

Xavier Becerra
Attorney General of California
Kathleen Boergers
Supervising Deputy Attorney General

Nimrod P. Elias
Karli Eisenberg
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
1300 I Street
Sacramento, CA 95814
(916) 210-7913
Karli.Eisenberg@doj.ca.gov
Attorneys for the State of California

October 4, 2019

Additional Counsel on Signature Page

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: October 4, 2019 *s/Karli Eisenberg*

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

CASES

STATUTES

TABLE OF AUTHORITIES
(continued)

Page

COURT RULES

OTHER AUTHORITIES

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

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.). Yet, Mississippi has enacted a near-total ban on abortions that takes effect before many women even know they are pregnant. S.B. 2116 makes it a criminal offense to perform an abortion if a "fetal heartbeat" is detected, thereby banning abortions beginning at approximately 6 weeks of pregnancy (with the narrowest of exceptions).[1] Because Mississippi's law prohibits women from exercising their right to obtain a pre-viability abortion (about 24 weeks), it is plainly unconstitutional. *Casey*, 505 U.S. at 856.

Mississippi claims its ban protects "maternal health and safety." Appellants' Opening Brief (AOB) at 8. However, as the American College of Obstetricians and Gynecologists have explained, "abortion is an essential component of health care for millions of women" and abortion bans, like Mississippi's, "increase[] women's health risks."[2] Amici States California, Colorado, Connecticut,

---

[1] *See Jackson Women's Health Organization v. Dobbs*, 379 F. Supp. 3d 549, 551 (S.D. Miss. 2018). The only exceptions are "to prevent the death of a pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman." ROA.1090.

[2] Am. Coll. of Obstetricians and Gynecologists Statement on Abortion Bans (May 9, 2019), https://www.acog.org/About-ACOG/News-Room/Statements/2019/ACOG-Statement-on-Abortion-Bans?IsMobileSet=false.

Delaware, Hawai‘i, Illinois, 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' challenge to the 6-week ban and, more generally, support access to abortion and contraceptives. Amici's interest in the provision of abortion services extends to patients who may be residents of amici States but present in Mississippi and therefore affected by the abortion ban at issue.[3]

Amici States share Mississippi's purported interests in protecting the health and safety of all women, including women of childbearing age. Amici States have taken several steps to protect maternal health, and recognize that reducing or eliminating access to safe and legal abortion leads to worse health outcomes for women. Amici States write to highlight some of the ways in which they have promoted women's health, including by expanding access to healthcare services and contraceptives, supporting maternal and infant healthcare 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 without diminishing women's constitutionally protected rights.

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

ARGUMENT

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

Nearly half a century ago, the Supreme Court recognized that women have a constitutional right to choose an abortion before viability. *Roe v. Wade*, 410 U.S. 113, 163 (1973). In 1992, the Supreme Court reaffirmed *Roe*'s "essential holding" that, before viability, "the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846. In the years that followed, the 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).[4]

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 gestational period as short as six weeks—thus barring them from getting an abortion for up to eighteen weeks before viability. *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (assessing viability at "about 24

[4] *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).

weeks"); *see also Casey*, 505 U.S. at 860 (viability "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*, 379 F. Supp. 3d at 552. 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 6 weeks is aimed at the "protection of maternal health." AOB at 9. However, 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.[5] Both the American Medical Association and the American College of Obstetricians and Gynecologists agree that "[a]ccess to safe and legal abortion benefits the health and wellbeing of women and their families."[6] Indeed, overwhelming scientific evidence establishes that highly restrictive abortion laws (like Mississippi's) lead to *worse* health

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

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

outcomes for women and also fail to lower abortion rates.[7] Moreover, there is a direct connection between restrictive abortion laws and higher maternal mortality rates.[8]

Barriers to abortion access also lead to 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 receive abortions.[9] For women who have pregnancies too close together, the Mayo clinic warns of several health risks to the woman and her child, including an increased risk of premature birth, low birth

---

[7] *Induced Abortion Worldwide*, Guttmacher Inst., 1-2 (March 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_iaw.pdf ("Abortion rates are similar in countries where abortion is highly restricted and where it is broadly legal."); Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, Women's Health Issues (2016), https://www.sciencedirect.com/science/article/pii/S1049386715001589.

[8] *See* Su Mon Latt, et al., *Abortion Laws Reform May Reduce Maternal Mortality; An Ecological Study in 162 Countries*, BMC Women's Health 19, Article Number: 1 (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0705-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).

[9] 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.

weight, congenital disorders, and schizophrenia.[10] Additionally, carrying an unwanted pregnancy to term can result in a woman remaining in contact with a violent partner and suffering physical violence.[11]

Lack of access to abortion also results in poorer socioeconomic outcomes, including lower rates of full-time employment and increased reliance on publicly funded safety-net programs.[12] As the evidence in the district court demonstrated, the "availability of abortion enables patients not to forgo educational economic opportunities due to unplanned childbirth, to provide care to existing family members, [and] to avoid raising children with an absent or unwilling partner."[13]

---

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

[11] 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/.

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

[13] *See* Dr. Sacheen Carr-Ellis Decl. ¶ 22, Dist. Ct. Doc. No. 101-2 at 5; *see also* Anna Bernstein, et al., *The Economic Effects of Abortion Access: A Review of the Evidence*, Center for Economics of Reproductive Health, Institute for Women's Policy Research (2019) https://iwpr.org/wpcontent/uploads/2019/07/B379_Abortion-Access_rfinal.pdf.

Mississippi's 6-week ban will harm women across the state.[14] The overwhelming majority of women who have an abortion "would have preferred to have had their abortion earlier," but were unable to do so due to factors including cost and access barriers.[15] Beyond cost and access barriers, many women will not even realize they are pregnant early enough to seek out abortion services.[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 the most from

---

[14] The effects of Mississippi's abortion ban are amplified by Mississippi's other obstacles to obtaining an abortion, such as a mandatory 24-hour waiting period after receiving state-mandated information, a requirement that women make two separate trips to the clinic before obtaining an abortion, and a ban on prescribing 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.

[15] 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.

[16] *See* Dr. Sacheen Carr-Ellis Decl. ¶¶ 12-16, Dist. Ct. Doc. No. 101-2 at 3-5 (explaining that many women do not know they are pregnant at six weeks and nearly all of the Jackson Women's Health Organization's patients obtain abortion care at or after six weeks).

[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/.

unconstitutional abortion restrictions like the one at issue here.[18] Women who learn of 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.[19]

Moreover, it is already difficult to access abortion in some parts of the country, including in Mississippi, which only has one clinic that provides abortions.[20] Although it is a "common medical procedure," many large cities in the United States do not have any clinics that offer abortions.[21] Women who live

---

[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 (2007), 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 541-553 (2005), https://doi.org/10.1016/S1472-6483(10)60832-2.

[20] Rachel K. Jones, et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. at 18 (2017), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf. (showing that 91% of women in Mississippi live in a county without an abortion clinic).

[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/.

in 27 major U.S. cities have to travel more than 100 miles to reach an abortion facility.[22] In 2014, women in Mississippi had to travel a median distance of 68.80 miles to obtain an abortion.[23] And in 2017, about 89% of U.S. counties—home to 38% of all women between the ages of 15-44—lacked an abortion clinic, and five states had only one clinic in the entire state.[24] These "abortion deserts" lead to the adverse consequences described above, including delays in care, negative mental health impacts, and consideration of self-induced abortion.[25]

III. STATES CAN PROMOTE WOMEN'S HEALTH WITHOUT LIMITING 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. In many circumstances, reasoned legislative judgments regarding healthcare receive a substantial degree of respect from courts. No principle, however, requires or

---

[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.

[25] 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.

permits uncritical judicial acceptance of legislative judgments that improperly discount—or even countenance—increased risks to women's health. Courts must always carefully assess whether a legislative action unduly burdens the right to abortion—including by putting women in physical peril, chilling them from seeking services, or curtailing or eliminating services due to physicians' professional and ethical responsibilities to avoid undue risk and to protect patient health. *See Whole Women's Health*, 136 S. Ct. at 2309-2318.

Moreover, there are a number of proven measures that States can take to advance women's health that do not include limiting access to abortion, as the experience of amici States illustrates. *Cf. Jackson Women's Health Organization*, 349 F. Supp. 3d at 540 n.22. It is further the amici States' experience that policies that support the health of pregnant women also benefit the health of their future children. Of course, to protect "potential life," States must enact policies that advance, rather than worsen, pregnant women's health, such as the policies discussed below. *Cf.* AOB at 13 (quoting *Casey*, 505 U.S. at 873-76). 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."[26] Indeed, "[c]ontraceptive use is a *key predictor* of whether a woman will have an abortion." [27]

Many States, though not Mississippi, have extended healthcare to millions of women by expanding Medicaid for childless adults with incomes up to 138% of the federal poverty line. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i). [28] Further, the federal government covers 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).[29] To date, 37 States and the District of Columbia, including all amici States, have expanded Medicaid,

---

[26] 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).

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

[28] *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Found., https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (showing that if Mississippi expanded Medicaid over 60,000 individuals would become eligible for healthcare coverage).

[29] States may also submit a Medicaid waiver or State Plan Amendment specifically related to family planning, which Mississippi has done. Jenna Walls, et al., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, Kaiser Family Found. (Sept. 15, 2016), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/; *States that have Expanded Eligibility for Coverage of Family Planning Services under Medicaid*, Kaiser Family Found. (May 1, 2019), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/.

resulting in approximately 12.7 million additional Americans receiving health coverage.[30] Those covered now include significantly more low-income women of reproductive age.[31] This increased access to health insurance coverage among women of reproductive age is important for women's health and overall well-being, as well as the health and well-being of their children.[32]

Amici States have also made significant strides in reducing maternal mortality rates.[33] The United States has the highest rate of maternal mortality in the

---

[30] *See Status of State Action on the Medicaid Expansion Decision*, Kaiser Family Found. (Sept. 20, 2019), https://tinyurl.com/y6uw6rhy.

[31] Emily Johnston, et al., *Impacts of the Affordable Care Act's Medicaid Expansion on Women of Reproductive Age*, Women's Health Issues, 28, no. 2 (Feb. 2018), https://www.whijournal.com/article/S1049-3867(17)30242-6/pdf (Medicaid expansions decreased the uninsurance rate among low-income women of reproductive age by 13.2%).

[32] *Id*. (explaining that women who gain coverage have reduced mortality rates, improved physical and mental health, increased compliance with recommended preventive services, decreased medical debt, and that these health improvements "translate to improved health outcomes for children").

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

developed world.[34] Every year more than 700 women die of pregnancy-related complications and more than 50,000 women experience a life-threatening complication.[35] While the majority of countries worldwide are reporting declining maternal mortality rates, the numbers in the United States are rising. From 2000 to 2014, maternal mortality in the United States has more than doubled, from 9.8 deaths per 1,000 live births in 2000 to 21.5 deaths per 1,000 live births in 2014.[36] 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

---

[34] 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.

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

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

childbirth.[37] These alarming numbers prompted Congress to pass the bipartisan Preventing Maternal Deaths Act of 2017.[38]

In response to rising maternal mortality rates, California 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 2006, California initiated the California Maternal Quality Care Collaborative, a multi-stakeholder organization committed to ending preventable morbidity, mortality, and racial disparities in California's maternity care.[39] The organization utilizes a data center, quality improvement initiatives, and extensive research to improve health outcomes for mothers and babies.[40] And these efforts have borne fruit. California has seen maternal mortality decline by 57% between 2006 to 2013, from 16.9 to 7.3 deaths

---

[37] *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/.

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

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

[40] *Id.*

per 100,000 live births.[41] Among the 50 states, maternal mortality is the lowest in California.[42]

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

California

California operates a variety of programs aimed at women's healthcare. California's Presumptive Eligibility for Pregnant Women program provides immediate, temporary coverage for prenatal care to low-income pregnant patients pending a formal Medicaid application.[43] Eligible women immediately receive prenatal care and prescriptions for conditions related to pregnancy.[44] California's Medi-Cal Access Program provides uninsured, middle-income pregnant women with comprehensive healthcare coverage through an enrollee's post-partum period,

---

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

[42] *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.

[43] *Info. on the Presumptive Eligibility for Pregnant Women*, Cal. Dep't of Health Care Servs., https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_women.aspx.

[44] *Id.*

The Family Planning, Access, Care, and Treatment program provides healthcare services to eligible low income women and men.[45] The Black Infant Health Program seeks to improve African-American infant and maternal health by using a group-based intervention strategy for improving African-American women's birth outcomes.[46] The 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.[47]

Colorado

Launched in 2007, Colorado's Family Planning Initiative provides low- or no-cost long-acting reversible contraceptives (LARCs) to low-income women. LARCs include intrauterine devices (IUDs) and implants, which are more than 99% effective, last 3 to 10 years, and require no further action after insertion,

---

[45] *Medi-Cal Access Program*, Cal. Dep't of Health Care Servs., https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-calAccessProgram.aspx; *Office of Family Planning*, Cal. Dep't of Health Care Servs., https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx/.

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

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

making them the easiest and most effective form of birth control. By mid-2015, the initiative provided LARCs to more than 36,000 women. As a result, the birth and abortion rates both declined by nearly 50% among teens aged 15-19, and by 20% for young women aged 20-24. It is estimated that Colorado avoided over $50 million in public assistance costs associated with unintended pregnancies.[48]

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 through quality improvement, performance monitoring, and evaluation.[49] Connecticut's Title V program seeks to improve maternal and child health through preventive interventions.[50] And the Every Woman Connecticut Learning

---

[48] *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.

[49] *Healthy Start*, Conn. 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.

[50] *Guidelines for the Sexual Health Educ. Component of Comprehensive Health Educ.*, Conn. State Dep't of Educ., https://portal.ct.gov/SDE/Publications/Sexual-

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.[51]

Delaware

Delaware has collaborated with Upstream USA to promote Delaware Contraceptive Access Now aimed at reducing the rate of unintended pregnancies.[52] UpStream USA provides training and technical support to ensure that all publicly funded healthcare providers and Delaware's largest private healthcare providers offer patients the full range of contraceptive methods. Between 2014 and 2017, long acting contraceptive use increased from 13.7% to 31.5% among Delaware Title X family planning patients, resulting in a 24% decrease in unintended pregnancies.

Additionally, Delaware's Healthy Women, Healthy Babies program facilitates extra services for women who are pregnant or planning to be pregnant. Delaware facilitates home visits to provide prenatal care, support, and education. Delaware

Health-Education-Component-of-Comprehensive-Health-Education/Components-of-Sexual-Health-Education.

[51] *Every Woman Conn.*, https://www.everywomanct.org/about-the-pibo.

[52] *Delaware CAN*, Upstream USA, https://www.upstream.org/campaigns/delaware-can/.

also established the Healthy Mother and Infant Consortium, which has decreased the number of infant deaths per year from 106 in 2005 to 72 in 2017.

District of Columbia

The District of Columbia has expanded access to contraceptives and health services for women. D.C. requires District-regulated individual and group health plans to cover all FDA-approved contraceptive drugs, devices, products, and services for women without cost-sharing. *See* D.C. Code § 31-3834.03. Further, the District requires individual and group health plans to cover a full-year supply of prescription contraceptives. D.C. Code § 31-3834.01. The same provision authorizes pharmacists to dispense up to a 12-month supply of a woman's covered contraceptive. *Id.* By facilitating the continuous use of contraceptives, the District aims to reduce unintended pregnancies. The District also requires its health facilities, and permits other qualified health providers, to offer contraceptive information, services, and devices, as well as prenatal and postnatal care, regardless of the patient's age. D.C. Mun. Reg. tit. 22-B, § 22-B603.

Illinois

Illinois maintains a Family Planning Program that provides high-quality pregnancy planning services to low-income individuals, thereby lowering the incidence of unintended pregnancies and sexually transmitted diseases; provides

HIV testing and counselling; and offers special teen clinics.[53] Illinois recently released a comprehensive Maternal Morbidity and Mortality Report that identifies statewide trends in maternal deaths and provides recommendations to prevent maternal mortality.[54] And the Illinois Breast and Cervical Cancer Program offers free mammograms, breast exams, pelvic exams, and pap tests, and treatment for women diagnosed with cancer.[55]

Maryland

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, healthcare providers, healthcare

---

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

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

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

facilities, and the public.[56] Maryland's Maternal, Infant, and Early Childhood Home Visiting program funds home visiting programs to address prenatal care, infant mortality, childhood immunizations, child abuse and neglect, and school readiness.[57] Maryland also provides educational training to hospital maternity staff to meet the Maryland Hospital Breastfeeding Policy Recommendations and Maryland's Baby Friendly Hospital Initiative.[58]

In 1998, Maryland mandated contraceptive coverage for certain state-regulated plans. In 2016, it extended the ACA's contraceptive-coverage requirements by expanding contraception options available without co-payment, requiring coverage of over-the-counter contraceptive medications, and expanding vasectomy coverage without cost-sharing and deductibles. In 2020, Maryland will begin providing coverage of up to twelve-months of birth control.

---

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

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

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

Massachusetts

Massachusetts established a Maternal Mortality and Morbidity Review Committee to review all maternal deaths within the state.[59] The Committee's mission is to study pregnancy complications and to make recommendations to improve maternal outcomes and prevent mortality.[60] 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.[61] Massachusetts women may also access family planning and reproductive healthcare through the Sexual and Reproductive Health Program, which funds 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.[62]

---

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

[60] *Id*.

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

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

Michigan

Michigan has implemented several programs to improve women's healthcare. Michigan established the Michigan Maternal Mortality Surveillance program to identify underlying factors associated with maternal deaths and to develop policy recommendations to reduce maternal mortality and eliminate racial and social disparities.[63] Michigan convened the Maternal Infant Strategy Group to align maternal and infant health stakeholders and improve health outcomes. Michigan also implemented a statewide population health plan aimed at reducing maternal and infant mortality 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 cesarean sections.[64]

Michigan also joined the Alliance for Innovation on Maternal Health to implement maternal patient safety in hospitals.[65] Michigan also offers

---

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

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

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

reproductive health services to women and men through a network of 31 local agencies and 92 clinics that provide services in 72 of Michigan's 83 counties.[66] And maternal home-visiting services are provided through various state initiatives.[67]

Minnesota

Minnesota's Maternal and Child Health Section provides an array of programs to improve the health status of women and their families.[68] For example, the Section operates the Family Planning Special Projects Grant Program, which funds family planning programs throughout Minnesota.[69] In 2018, the services provided by grantees reached 96,000 individuals through outreach activities, including providing counselling to 40,267 individuals, and providing 29,641 men

---

[66] *Family Planning*, Mich. Dep't of Health and Human Servs., https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_6216---,00.html.

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

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

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

and women with a range of family planning method services, with 25.6% of women choosing a "Tier 1 or most effective method."[70]

Nevada

Nevada requires its licensed insurance plans to cover contraception services. Nev. Rev. Stat. §§ 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, and 695C.1696. Additionally, Nevada recently expanded access to contraception through its family planning grant program by: (1) expanding eligible providers to include community health nurses; (2) expanding the reimbursable contraception services to including emergency contraception; and (3) increasing funding for the grant program from $1 million to $6 million. Lastly, Nevada removed the requirement that a physician certify a woman's marital status prior to performing an abortion.

Additionally, Nevada's Maternal and Child Health (MCH) program "is dedicated to improving the health of families, with an emphasis on women, infants, and children. . . . "[71] MCH implements the Maternal and Infant Health Program, whose mission "is to improve the health and well-being of pregnant women and

---

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

[71] *Title V MCH Program*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/.

infants and decrease infant and maternal morbidity and mortality."[72] Nevada addresses substance use and pregnancy;[73] provides free in-home visits "to pregnant women, mothers, fathers, and caregivers";[74] uses the Pregnancy Risk Assessment Monitoring System "to learn more about ways to improve the health of mothers and babies";[75] and utilizes the Collaborative Improvement and Innovation Network to "reduce infant mortality and improve birth outcomes."[76] Nevada is also committed to preventing teen pregnancy through educational programs on personal responsibility targeting "high-risk adolescents, aged of 13 – 18 years old."[77]

---

[72] *Maternal and Infant Health Program*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/MIP/MIP-Home/.

[73] *About Us*, Sober Moms, Healthy Babies, https://sobermomshealthybabies.org/about-us/.

[74] *Nev. Home Visiting*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/MIECHV/Nevada_Home_Visiting_(MIECHV)_-_Home/.

[75] *Pregnancy Risk Assessment Monitoring System*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/PRAMS/PRAMS/.

[76] *Cribs for Kids – Safe Sleep*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/MIP/dta/Links/links/.

[77] *Teen Pregnancy Prevention-Personal Responsibility Educ.*, Nev. Div. of Pub. and Behavior Health, http://dpbh.nv.gov/Programs/PREP/PREP-Home/

New Mexico

New Mexico offers low- or no-cost clinical services in the State's 32 public health offices and school-based health centers.[78] New Mexico's family planning program offers clinical services including laboratory tests, counselling, and birth control and supports community-based programs for teens including comprehensive sex education and adult-teen communication programs. Through the family planning program, New Mexico addresses healthcare needs of hard-to-reach and low-income populations through outreach activities while aiming to reduce unintended pregnancies.

New Mexico also offers voluntary home visiting programs for newborns and mothers, helping low-income women gain access to medical, social, and educational services to support positive pregnancy outcomes, healthy infants, and children.[79] New Mexico also treats maternal depression through a network of postpartum support coordinators.[80] Between 2012 and 2015, there was an increase in the percentage of mothers who began prenatal care during the first trimester of

---

[78] *Family Planning Program*, N.M. Dep't of Health, https://nmhealth.org/about/phd/fhb/fpp/.

[79] *Families FIRST Program*, N.M. Dep't of Health, https://nmhealth.org/about/phd/fhb/ffp/.

[80] *Maternal Depression Screening*, Medical Home Portal, https://nm.medicalhomeportal.org/clinical-practice/screening-and-prevention/maternal-depression

pregnancy, an increase in breastfeeding,[81] and an increase in mothers who participated in a home visit during pregnancy as well as a reduction in the rate of unwanted pregnancies.[82]

New York

New York has established a Maternal Mortality Review Board and increased the number of community health workers who serve pregnant and postpartum women and families, established an expert panel to make recommendations to improve postpartum care, and developed a perinatal data module and implicit bias training. 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.[83] New York has also implemented numerous programs that promote maternal and infant health and well-being. The Healthy Families New York Home

---

[81] *Breastfeeding in New Mexico-Positive Trends and Gains*, N.M. Dep't of Health, https://nmhealth.org/data/view/newsletter/1939/ (Breastfeeding increased by 10% between 2000 through 2013).

[82] Pregnancy Risk Assessment Monitoring System, https://www.cdc.gov/prams/prams-data/mch-indicators/states/pdf/2015/New-Mexico-508.pdf.

[83] 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; *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).

Visiting Program offers home-based services to support expectant families and new parents, at no cost to the beneficiaries.[84] 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.[85] 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.[86] And lastly, the New York State Department of Health funds 48 agencies at more than 170 sites that provide accessible, confidential reproductive healthcare services to women, men, and adolescents, especially low-income individuals and those without health insurance.[87] In 2016, more than 300,000 women and men received

---

[84] *Healthy Families N.Y.*, https://www.healthyfamiliesnewyork.org /HomeVisits/Process.htm.

[85] *N.Y. State Dep't of Health – Pathways to Success*, U.S. Health and Human Servs., https://www.hhs.gov/ash/oah/grant-programs/ pregnancy-assistance-fund/successful-strategies/nysdoh-pathways-to-success/ index.html.

[86] *Maternal and Infant Cmty. Health Collaboratives Initiative,* N.Y. State Dep't of Health, https://www.health.ny.gov/community/adults/women/ maternal_and_infant_comm_health_collaboratives.htm.

[87] *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/.

services through this state-funded family planning program, and more than 50,000 of those beneficiaries were adolescents.[88]

The New York Comprehensive Family Planning & Reproductive Health Program provides low income women, men, and communities of color with access to affordable high quality family planning care.[89] In 2017, this program served 301,128 clients at 470,973 family planning visits and the program successfully reached underserved communities.[90] In 2017, 21.5% of the female clients served by the program left the clinic with what is deemed a "most effective" contraceptive (a long acting reversible contraceptive) and 67.5% of the female clients left with a "moderately effective" contraceptive method (such as prescription birth control pills).[91] Further, 69% of the clients served through the program that year were reported to have no other source of medical care.[92]

---

[88] *Id*.

[89] *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/.

[90] Lauren Tobias Decl., *State of Oregon v. Azar*, Dist. Ct. of Oregon, No. 19-cv-00317, Doc. No. 66, at 6 (March 21, 2019).

[91] *Id.* at 7.

[92] *Id.* at 8.

Pennsylvania

Pennsylvania has taken a number of steps in recent years to reduce its maternal mortality rate. Last year, Pennsylvania enacted the "Maternal Mortality Review Act." 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[ing] recommendations for the prevention of future maternal deaths." *Id.* § 5(a). The Commonwealth also expanded Medicaid in 2015, and as a result more than 700,000 Pennsylvanians obtained health coverage.

Rhode Island

Rhode Island recently created a maternal mortality review committee to review maternal deaths of women that occur during pregnancy, delivery, or within one year after birth with the goal of reducing such deaths. *See* R.I. Gen. Laws § 23-4-3 (12)(i). Additionally, the Rhode Island Department of Health's (RIDOH) Maternal & Child Health Program works to support and promote the health of mothers, children, and families to reduce inequities and improve outcomes.[93] RIDOH's Family Visiting Program provides prenatal support and services for infants and toddlers, personalized attention for women and their children, and tips

[93] *Maternal & Child Health Program*, R.I. Dep't of Health, http://health.ri.gov/programs/detail.php?pgm_id=1126.

to support baby development and growth, including the Nurse-Family Partnership, a free program to help pregnant women find prenatal care and become more knowledgeable about pregnancy, labor and delivery, and childhood growth and development.[94] RIDOH also offers family planning services on an income-based sliding fee, including birth control education, pregnancy testing, and diagnosing and treating sexually transmitted diseases.[95] Finally, the Rhode Island Executive Office of Health & Human Services administers Rhode Island's Medicaid managed care program for families with children, pregnant women, and children under age 19, allowing low-income families to access services like prenatal care and childbirth and parenting education programs.[96]

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 through a

---

[94] *Family Visiting, Nurse-Family Partnership*, R.I. Dep't of Health, http://health.ri.gov/find/services/detail.php?id=36.

[95] *Family Planning Servs.*, R.I. Dep't of Health, http://health.ri.gov/find/services/detail.php?id=25.

[96] *Healthcare Programs*, R.I. Exec. Office of Health & Human Servs., http://www.eohhs.ri.gov/Consumer/FamilieswithChildren/HealthcarePrograms.aspx.

statewide network of family planning health centers, many of them in rural communities.[97] Vermont's Title V maternal and child health block grant program provides leadership for clinical, community, and public health services and systems for Vermont's maternal and child population.[98] Program examples 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.[99] The Personal Responsibility and Education Program ensures that Vermont youth can access evidence-based teen pregnancy and sexual health programming across a network of youth serving

---

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

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

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

organizations.[100] Maternal and Child Health programming also includes activities related to prevention of sexual violence and increasing knowledge and skills related to healthy relationships, health sexuality, and bystander engagement.[101]

* * *

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

CONCLUSION

The district court's judgment should be affirmed.

---

[100] *Id.*

[101] *Prevent Domestic and Sexual Violence,* Vt. Dep't of Health, http://www.healthvermont.gov/children-youth-families/healthy-relationships/prevent-domestic-and-sexual-violence.

Dated: October 4, 2019

Respectfully submitted,

s/ Karli Eisenberg
Karli Eisenberg

XAVIER BECERRA
Attorney General of California
KATHLEEN BOERGERS
Supervising Deputy Attorney General
NIMROD P. ELIAS
KARLI EISENBERG
Deputy Attorneys General
Attorneys for the State of California

(Counsel listing continues on next page)

PHIL WEISER
Attorney General
State of Colorado

KEITH ELLISON
Attorney General
State of Minnesota

WILLIAM TONG
Attorney General
State of Connecticut

AARON D. FORD
Attorney General
State of Nevada

KATHLEEN JENNINGS
Attorney General
State of Delaware

HECTOR BALDERAS
Attorney General
State of New Mexico

KARL A. RACINE
Attorney General
District of Columbia

LETITIA JAMES
Attorney General
State of New York

CLARE E. CONNORS
Attorney General
State of Hawai‘i

ELLEN F. ROSENBLUM
Attorney General
State of Oregon

KWAME RAOUL
Attorney General
State of Illinois

JOSH SHAPIRO
Attorney General
Commonwealth of Pennsylvania

AARON M. FREY
Attorney General
State of Maine

PETER F. NERONHA
Attorney General
State of Rhode Island

BRIAN E. FROSH
Attorney General
State of Maryland

THOMAS J. DONOVAN, JR.
Attorney General
State of Vermont

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts

MARK R. HERRING
Attorney General
Commonwealth of Virginia

DANA NESSEL
Attorney General
State of Michigan

ROBERT W. FERGUSON
Attorney General
State of Washington

CERTIFICATE OF SERVICE

I certify that on October 4, 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: October 4, 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 6,425 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: October 4, 2019 *s/Karli Eisenberg*