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 Director 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 (JACKSON)
NO. 3:18-cv-00171

BRIEF FOR *AMICUS CURIAE* INFORMATION SOCIETY PROJECT AT YALE LAW SCHOOL IN SUPPORT OF PLAINTIFFS-APPELLEES AND SUPPORTING AFFIRMANCE OF THE DISTRICT COURT

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CERTIFICATE OF INTERESTED PERSONS

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Defendants-Appellants.

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

1. Sacheen Carr-Ellis, M.D., M.P.H., Plaintiff-Appellee.
2. All Women's Healthcare of Jackson d/b/a Jackson Women's Health Organization, Plaintiff-Appellee.
3. Diane Derzis, owner of Jackson Women's Health Organization.
4. Hillary Schneller, Counsel for Plaintiff-Appellees.
5. Julie Rikelman, Counsel for Plaintiff-Appellees.

6. Leah Wiederhorn, Counsel for Plaintiff-Appellees.
7. Christine Parker, Counsel for Plaintiff-Appellees.
8. Claudia Hammerman, Counsel for Plaintiff-Appellees.
9. Roberto J. Gonzalez, Counsel for Plaintiff-Appellees.
10. Aaron S. Delaney, Counsel for Plaintiff-Appellees.
11. Caitlin Grusauskas, Counsel for Plaintiff-Appellees.
12. Alexia D. Korberg, Counsel for Plaintiff-Appellees.
13. Crystal Johnson, Counsel for Plaintiff-Appellees.
14. Robert B. McDuff, Counsel for Plaintiff-Appellees.
15. Beth L. Orlansky, Counsel for Plaintiff-Appellees.
16. Dr. Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health, Defendant-Appellant.
17. Dr. Kenneth Cleveland, Executive Director of the Mississippi State Board of Medical Licensure, Defendant-Appellant.
18. Mississippi Department of Health, Defendant-Appellant.
19. Mississippi State Board of Medical Licensure, Defendant-Appellant.
20. Paul E. Barnes, Counsel for Defendant-Appellants.
21. Wilson Minor, Counsel for Defendant-Appellants.
22. Robert Shuler Smith, District Attorney for Hinds County, Mississippi, Non-Appealing Defendant.

23. Robert E. Sanders, Counsel for Robert Shuler Smith.
24. Gerald Mumford, County Attorney for Hinds County, Mississippi, Non-Appealing Defendant.
25. Pieter Teeuwissen, Counsel for Gerald Mumford.
26. Wendy Wilson-White, City Prosecutor for the City of Jackson, Mississippi, Non-Appealing Defendant.
27. Lashundra B. Jackson-Winters, Counsel for Wendy Wilson-White.
28. Phil Bryant, Governor of Mississippi, Amicus Curiae.
29. John Bursch, Counsel for Amicus Curiae Phil Bryant.
30. Roman Catholic Diocese of Jackson, Mississippi, Amicus Curiae.
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33. Stephen J. Carmody, Counsel for Amici Curiae Roman Catholic Dioceses.
34. State of Louisiana, Amicus Curiae.
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36. Jeff Landry, Attorney General of Louisiana, Counsel for Amici Curiae States of Louisiana and Texas.
37. Ken Paxton, Attorney General of Texas, Counsel for Amici Curiae States of Louisiana and Texas.
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41. Beth Klusman, Counsel for Amici Curiae States of Louisiana and Texas.
42. Information Society Project at Yale Law School, Amicus Curiae.
43. Priscilla J. Smith, counsel for Amicus Curiae Information Society Project at Yale Law School.

Amicus Curiae Information Society Project at Yale Law School has no parent corporation and no publicly owned corporation owns 10% or more of its stock.

DATED: April 12, 2019

/s/ Priscilla J. Smith
Priscilla J. Smith
Attorney of Record for Amicus Curiae Information Society Project at Yale Law School

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INTEREST OF AMICUS CURIAE[1]

Amicus is the Information Society Project (ISP) at Yale Law School,[2] an intellectual center exploring the implications of new technologies for law and society. The ISP focuses on a wide range of issues such as the intersections between the regulation and dissemination of information, health policy, privacy concerns, First Amendment and reproductive rights jurisprudence, and technology policy. Many of the scholars associated with the ISP have special expertise in First, Fourth, and Fourteenth Amendment jurisprudence and share an interest in ensuring that the constitutionality of abortion regulations is determined in accordance with settled Fourteenth Amendment principles.

SUMMARY OF ARGUMENT

The District Court properly found that H.B. 1510[3] runs afoul of Supreme Court jurisprudence by imposing a blanket ban on pre-viability abortions after fifteen weeks of pregnancy. *Jackson Women's Health Org. v. Currier*, 349 F. Supp. 3d 536 (S.D. Miss. 2018). As a result, the law is a *per se* undue burden without any need for a balancing test. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833,

[1] This brief is submitted under Fed. R. App. P. 29(a) with the consent of all parties. Pursuant to Fed. R. App. P. 29(a)(4)(E), no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than the amicus curiae, its members, or its counsel contributed money that was intended to fund preparing or submitting this brief.

[2] This brief has been filed on behalf of a Center affiliated with Yale Law School but does not purport to represent the school's institutional views, if any.

[3] H.B. 1510, 2018 Leg., Reg. Sess. (Miss. 2018).

879 (1992). We argue here that H.B. 1510 is also unconstitutional for two additional reasons.

First, while H.B. 1510 takes away women's choice *after* fifteen weeks' gestational age contrary to relevant precedent, the law also imposes an undue burden on women who seek an abortion even *before* fifteen weeks because it forces them to make a decision about abortion before they may be fully informed about the medical consequences of their pregnancy. Such a law violates *Casey*, which not only protects a woman's right to an abortion but also reflects her interest in being fully informed about her decision. *Id.* at 877 ("[T]he means chosen by the State . . . must be calculated to inform the woman's free choice, not hinder it.").

Pregnancy presents many potential health risks for women. It can seriously exacerbate preexisting medical conditions, and new and serious health issues can emerge during pregnancy as well. Women with chronic medical conditions such as hypertension, diabetes, and a host of other diseases may seek to manage them before becoming pregnant. However, as the pregnancy progresses, additional complications often arise, and doctors have a limited ability to predict these outcomes before they manifest. Additionally, women may face unforeseen and serious health problems after the fifteen-week mark, such as chorioamnionitis and complications from certain types of fetal anomalies. By preventing a woman from making a fully informed medical decision that takes into account the numerous health risks and

complications that may not be evident until after fifteen weeks of pregnancy, H.B. 1510 imposes an undue burden on a woman's abortion right. In fact, by forcing women to make a choice before they may have access to all of the facts about their pregnancy, H.B. 1510 may even lead to the termination of wanted pregnancies due to fear of risks to a woman's health that may never materialize.

H.B. 1510's medical exception is inadequate to address these concerns because it is overly narrow. The medical exception does not apply to women seeking pre-viability abortions who face substantial health risks that fall outside H.B. 1510's narrow exception. The bill could also force women whose pregnancy complications arise or worsen after fifteen weeks to wait to terminate their pregnancy until their condition has worsened to such an extent that it falls within the narrow exceptions. This would force them to endure increased health problems that would have been avoided if they were able to get an abortion when the health concerns had originally manifested, but before they had reached the level of emergency required by H.B. 1510.

Second, H.B. 1510 reinforces the stereotype that a woman's most important function in life is to bear and raise children, even at risk to her health. The Supreme Court has reaffirmed repeatedly that laws that enforce sex-role stereotypes unconstitutionally discriminate on the basis of sex, in violation of the Equal Protection Clause. *E.g.*, *United States v. Virginia*, 518 U.S. 515, 533 (1996)

("[The State] must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females."); *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975); *Frontiero v. Richardson*, 411 U.S. 677 (1973).[4] *See also Casey*, 505 U.S. at 897 ("Only one generation has passed since this Court observed that 'woman is still regarded as the center of home and family life,' with attendant 'special responsibilities' that precluded full and independent legal status under the Constitution . . . . These views, of course, are no longer consistent with our understanding of the family, the individual, or the Constitution." (quoting *Hoyt v. Florida*, 368 U.S. 57, 62, 86 (1961))).

Finally, although the law's defenders claim that H.B. 1510 protects both fetal life and maternal health, Mississippi's other policy choices indicate that these stated rationales for the law are merely pretextual. Mississippi has some of the worst maternal and infant health outcomes in the country. Yet outside of the abortion context, Mississippi fails to act in a way that would promote these stated interests. It has declined opportunities to provide additional financial support for motherhood

[4] Again, in this case, *supra* at 2, a balancing analysis is unnecessary because any ban on previability abortions is a *per se* undue burden. However, in a case unlike this one where the court must balance the benefits of an abortion restriction against the burdens it imposes in accordance with *Whole Women's Health*, 136 S. Ct. at 2309, *but see June Med. Servs. L.L.C. v. Gee*, 905 F.3d 787 (5th Cir. 2018), *stay granted pending filing and disposition of petition for cert*., 139 S. Ct. 663 (2018), it may also be appropriate to consider the burdens of sex discrimination under the undue burden balancing analysis. *See Tucson Women's Clinic v. Eden*, 379 F.3d 531, 549 (9th Cir. 2004) ("[E]lements of intermediate scrutiny review particular to sex-based classifications, such as the rules against paternalism and sex-stereotyping, are evident in the *Casey* opinion, and should be considered by courts assessing the legitimacy of abortion regulation under the undue burden standard." (internal citations omitted)).

and has failed to take steps to reduce unplanned pregnancies, which would consequently lower the number of abortions. That Mississippi's pro-natal policies are limited to the abortion context demonstrates that its true interests are in blocking abortion and limiting women's reproductive health access, thereby perpetuating gender stereotypes.

ARGUMENT

I. H.B. 1510 Unconstitutionally Burdens Women Who Seek an Abortion Prior to Fifteen Weeks' Gestation.

As the District Court correctly found, H.B. 1510 is unconstitutional because it imposes a blanket ban on pre-viability abortions after fifteen weeks' gestation. *Jackson Women's Health Org.*, 349 F. Supp. 3d at 540. Because H.B. 1510 is a pre-viability abortion ban, there is no place for a balancing test, since no state interest can justify the ban as a matter of law. *Id.* at 540-41; *see also Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) ("Before viability, a State 'may not prohibit any woman from making the ultimate decision to terminate her pregnancy.'" (quoting *Casey*, 505 U.S. at 879)); *Casey*, 505 U.S. at 846 ("Before viability, the State's interests are not strong enough to support a prohibition of abortion."). H.B. 1510 presents a simple case of a pre-viability ban that is per se unconstitutional.

There is another angle, however, from which to consider H.B. 1510. Not only does the law take away women's choice after fifteen weeks in a manner that flatly contradicts Supreme Court precedent, it also forces women to make a choice whether

or not to have an abortion *before* fifteen weeks. Although the state has attempted to justify H.B. 1510 in part on the grounds of maternal health, *see, e.g.*, Br. for Defs.-Appellants at 5, 30, 40-41, forcing women to make this choice prior to fifteen weeks undermines women's health and imposes burdens on these women as well.

A. The Arbitrary Fifteen-Week Cutoff Imposed by H.B. 1510 Forces Women to Be Substantially Less Informed About the Health Risks of Their Pregnancies.

While many women carry pregnancies to term safely, for others, pregnancy is a dangerous condition with numerous health risks. Access to safe and legal abortion is necessary to prevent many of these negative health outcomes. Indeed, the prevailing medical research makes clear that legal abortion is both dramatically safer than childbirth and is "associated with substantially less pregnancy-related morbidity."[5] Moreover, experts note that studies may even "underestimate the relative safety of choosing abortion over continuing a pregnancy."[6]

Women who choose to carry a pregnancy to term open themselves up to a host of potential complications, including those stemming from preexisting conditions which may be exacerbated by pregnancy. It is often impossible to predict the extent of complications that may arise from preexisting conditions, and new and severe

[5] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) OBSTETRICS & GYNECOLOGY 215, 217 (2012); *see also* National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 63, 74-76 (2018), https://www.nap.edu/read/24950/chapter/1.
[6] Raymond & Grimes, *supra*, at 217-18.

conditions may originate after the fifteen-week mark. H.B. 1510 forces women to choose whether to endure the significant risks of pregnancy and childbirth before they can be fully informed as to the nature and extent of those risks. Forcing this uninformed choice constitutes a significant and unconstitutional burden on a woman's right to obtain a pre-viability abortion.

1. The Extent of Complications Arising from Preexisting Conditions May Be Impossible to Determine Prior to Fifteen Weeks' Gestation.

Pregnancy can exacerbate many chronic medical conditions in ways that impose additional risks to the health of the pregnant woman. Women with these conditions may attempt to carry to term by safely managing the condition, but they and their loved ones sometimes choose this option only because women retain the option to terminate if their health deteriorates. The conditions which can create heightened risk during pregnancy are numerous and varied. For example, a woman with preexisting hypertension is at a higher risk of developing preeclampsia, a complication of pregnancy that affects various vital organs.[7] Untreated preeclampsia can evolve into eclampsia, a condition defined by the presence of seizures, which is one of the leading causes of maternal and neonatal mortality.[8] Preeclampsia typically does not develop until at least the second trimester, and delivery is typically the

[7] Noura Al-Jameil et al., *A Brief Overview of Preeclampsia,* 6 J. CLINICAL MED. RES. 1, 1 (2014).
[8] *Id.*

treatment recommendation for moderate or severe preeclampsia that does not improve with hospitalization.[9] Similarly, when a woman is suffering from pulmonary hypertension during the second trimester, when a fetus is not yet viable, the best treatment option may be abortion.[10] H.B. 1510's fifteen-week cutoff eliminates that option, placing women at a higher risk for continued severe complications and even death and preventing women who are at higher risk of developing the condition from making this decision before fifteen weeks.

Similarly, diabetes is a chronic condition that can worsen significantly during pregnancy. Even when their condition is carefully managed, pregnant diabetic women are at significant risk for developing hypoglycemia.[11] This dangerous complication places women at risk of severe complications including seizures and diabetic coma.[12] Gestational diabetes, with the same significant risks, manifests only during pregnancy,[13] and screening for the condition does not occur until twenty-four to twenty-eight weeks' gestation.[14] Consequently, women with preexisting or

[9] F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 717 (20th ed. 1997).
[10] Charles Bowers et al., *Dilation and Evacuation During the Second Trimester of Pregnancy in a Woman with Primary Pulmonary Hypertension*, 33 J. REPROD. MED. 787 (1988).
[11] Gita Shafiee et al., *The Importance of Hypoglycemia in Diabetic Patients*, 11 J. DIABETES & METABOLIC DISORDERS 17, 19 (2012).
[12] *Id.* at 17. For other complications associated with diabetes, see, for example, Michael F. Greene & Jeffrey L. Ecker, *Abortion, Health, and the Law*, 350 N. ENGL. J. MED. 184, 184-85 (2004) ("A diabetic woman with active proliferative retinopathy may risk blindness if a pregnancy is carried to term.").
[13] American College of Obstetricians & Gynecologists, *Gestational Diabetes* (Nov. 2017), https://www.acog.org/Patients/FAQs/Gestational-Diabetes?IsMobileSet=false.
[14] *Id.*

gestational diabetes may be unaware of either the diagnosis or all attendant dangers associated with their pregnancy until well past the fifteen-week point.

Many other preexisting conditions likewise worsen later in pregnancy. Heart conditions such as valvular disease and high-grade mitral valve stenosis put women at a higher risk of complications.[15] So too can renal diseases, including Alport Syndrome.[16] Systemic lupus erythematosus (SLE) may also cause complications, particularly during the second trimester.[17] And these potentially dangerous conditions represent only a small fraction of the various serious medical conditions which can be exacerbated by pregnancy.[18] H.B. 1510 forces women with any of these conditions to choose whether to terminate or continue their pregnancy before the extent of their various potential complications becomes clear.

2. High-Risk and Unpredictable Health Risks May Arise After the Fifteen-Week Mark.

In addition to chronic conditions that may worsen during pregnancy, a number of conditions manifest only in the second trimester or later, meaning that pregnant

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[15] *See, e.g.*, Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 HEART 552 (2007); Sharon C. Reimold & John D. Rutherford, *Valvular Heart Disease in Pregnancy*, 349 N. ENGL. J. MED. 52 (2003).

[16] K. Edipidis, *Pregnancy in Women with Renal Disease: Yes or No?*, 15 HIPPOKRATIA 8 (2011); Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 OBSTETRICS & GYNECOLOGY 531 (2007).

[17] Josefina Cortés-Hernández et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 RHEUMATOLOGY 643 (2002).

[18] *See generally Section X: Common Complications of Pregnancy*, *in* WILLIAMS OBSTETRICS, *supra*, at 693-894.

women can never be adequately informed of all their risks prior to fifteen weeks' gestation. One of the most dangerous of these is chorioamnionitis, an infection of the uterine lining that can develop from premature rupture of membranes. When left untreated, rupture can lead to chorioamnionitis, which in turn can lead to sepsis or other complications, including postpartum hemorrhage, respiratory distress syndrome, or even death.[19]

In addition to chorioamnionitis, women may suffer serious complications from certain kinds of fetal anomalies.[20] As with other conditions, it is almost impossible for women to be adequately aware of these risks prior to fifteen-weeks' gestation, as genetic screenings are only able to diagnose certain physical defects and chromosomal abnormalities, such as trisomy 13 or trisomy 18, during the second trimester.[21]

3. H.B. 1510's Medical Exception Fails to Adequately Address the Burdens Imposed by the Fifteen-Week Ban.

The medical emergency exception provided in H.B. 1510 allows for abortion after fifteen weeks only in the event of a "medical emergency" which would create "a serious risk of substantial and irreversible impairment of a major bodily function."

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[19] Alan T.N. Tita & William W. Andrews, *Diagnosis and Management of Clinical Chorioamnionitis*, 37 CLINICAL PERINATOL 339, 346 (2010).
[20] Karen McNamara et al., *Antenatal and Intrapartum Care of Pregnancy Complicated by Lethal Fetal Anomaly*, 15 OBSTETRICIAN & GYNAECOLOGIST 189, 191 (2013).
[21] American College of Obstetricians & Gynecologists, *Prenatal Genetic Diagnostic Tests* (Jan. 2019), https://www.acog.org/Patients/FAQs/Prenatal-Genetic-Diagnostic-Tests.

H.B. 1510, § 1(3)(j). This exception is so narrow that it fails to protect women who need abortions to safeguard their health before their problems escalate to this level. It would force women to speculate about the health risks they may encounter should they choose to carry to term, and to wonder what level of risk their doctor would consider "serious."

In many cases, women with chronic health conditions do not consult with their doctor prior to becoming pregnant, "because many patients do not appreciate the potential for complications associated with pregnancy and because 50 percent of all pregnancies in the United States are unplanned."[22] In such cases, women may not consult with the proper specialists to diagnose their condition or inform them of the associated risks until well past the fifteen-week mark. Moreover, many complications manifest initially in a mild form before worsening gradually over time. This means that the risk posed at the time of diagnosis may not immediately fit the narrow definition of "medical emergency" provided by H.B. 1510.

The consequence of the law's inadequate and narrow exception is that women are forced to suffer through severe and often painful complications, while foregoing effective treatment until their condition becomes emergent under the statutory definition. Forcing physicians to wait until a patient's condition is emergent and

[22] Greene & Ecker, *supra*, at 184.

thereby cause unnecessary suffering and risk also violates basic ethical norms, including the principle of "Do No Harm."[23] This kind of unnecessary delay is particularly dangerous, as these conditions often escalate quickly and may become emergent or life threatening with very little warning.[24] It can also result in tragedy.[25]

B. By Forcing Women to Make a Decision About Abortion Before They May Be Fully Informed of the Health Risks of Pregnancy, H.B. 1510 Imposes an Undue Burden.

As a blanket ban after fifteen weeks, H.B. 1510 is unconstitutional. But H.B. 1510's effect on women's decisions *before* fifteen weeks is *also* in violation of *Casey* and *Whole Women's Health*. *Casey* provides that a law unconstitutionally infringes on a woman's right to an abortion if it imposes an undue burden on that right, meaning that it has the purpose or effect of placing a substantial obstacle in the path of the woman seeking the abortion. *Casey*, 505 U.S. at 877. H.B. 1510 forces women with health conditions to make a decision before they are fully informed

[23] American College of Obstetricians & Gynecologists, *Code of Professional Ethics* 2 (Dec. 2018), https://www.acog.org/About-ACOG/ACOG-Departments/Committees-and-Councils/Volunteer-Agreement/Code-of-Professional-Ethics-of-the-American-College-of-Obstetricians-and-Gynecologists?IsMobileSet=false ("The obstetrician-gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.").

[24] CRITICAL CARE OBSTETRICS 3 (Gary A. Dildy III et al., eds., 4th ed. 2004).

[25] *See, e.g.*, Megan Specia, *How Savita Halappanavar's Death Spurred Ireland's Abortion Rights Campaign*, N.Y. TIMES (May 27, 2018), https://www.nytimes.com/2018/05/27/world/europe/savita-halappanavar-ireland-abortion.html (discussing the case of a woman in Ireland who died after contracting septicemia following doctors' refusal to perform an abortion during her miscarriage even though the law contained an exception for circumstances where the woman's life was at risk).

about the health risks and consequences of their pregnancy. Such an effect is an unconstitutional undue burden.

Central to *Casey*'s vision is the idea that a woman must be fully informed about the consequences of pregnancy and abortion before she makes the decision to have, or not have, an abortion. Adequate information is essential to the woman's "effective right to elect" an abortion protected by *Casey*, and obstacles to obtaining such information constitute "undue interference" of the type *Casey* guards against. 505 U.S. at 846. *Casey* specifically recognized the importance of such information by providing that any statute with the purpose of placing a substantial obstacle to obtaining an abortion would be invalid "because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.* at 877. Similarly, the plurality held that the state may take measures to "ensure that the woman's choice is informed." *Id.*

In upholding Pennsylvania's informed consent requirement, the *Casey* plurality recognized a "substantial government interest justifying a requirement that a woman be apprised of the health risks of abortion and childbirth," and that a woman should be "fully informed" by "[apprehending] the full consequences of her decision." *Id.* at 882. To that end, a state can adopt measures aimed at ensuring a "mature and informed" decision and the "wise exercise" of the abortion right. *Id.* at 883, 887. While these factors supported Pennsylvania's informed consent

requirement, they militate against any law that prevents a woman from having access to all relevant information as she decides whether or not to have an abortion.

The importance of fully informed consent prior to abortion has been reaffirmed repeatedly post-*Casey*. *See, e.g.*, *Gonzales*, 550 U.S. at 159 ("The State has an interest in ensuring so grave a choice is well informed."); *Tex. Med. Providers Performing Abortion Services v. Lakey*, 667 F.3d 570, 585 (5th Cir. 2012) (Higginbotham, J., concurring) ("*Casey* spoke of frameworks for affording a woman accurate information relevant to the risks attending her decision . . . . [The woman's] fully informed decision cannot be frustrated by the state."). A law that requires a woman to make a decision about an abortion before it is possible for her to access full information about her particular pregnancy violates the principles of *Casey*. Such a law has the effect of placing a substantial obstacle in the path of the woman's constitutionally protected ability to freely decide whether or not to have an abortion.

H.B. 1510 squarely falls into this impermissible category. The law prevents a woman from making a fully informed medical decision with respect to her particular circumstances by denying her the ability to take into account the numerous health risks and complications of pregnancy that may not be evident or fully known until after the fifteen-week mark, as discussed in Part I.A, *supra*. This is particularly true for women with preexisting conditions, such as hypertension and diabetes, which can unpredictably worsen. Even if a woman never experiences a medical

complication during her pregnancy, she is burdened by being forced to make the decision of whether or not to have an abortion without being fully aware of the potential implications. Furthermore, even when doctors are able to predict the likelihood of potential complications, women lose the opportunity to "wait and see." Instead, the ban forces women to choose between terminating what may be a wanted pregnancy out of fear of risks to her health or proceeding with a pregnancy that may lead to severe health consequences.

These constitutional issues are particularly acute when the state hinders women's ability to be fully informed about their own health, given the importance the Supreme Court has placed on protecting the life and health of the pregnant woman. *See, e.g.*, *Casey*, 505 U.S. at 878-79; *Gonzales*, 550 U.S. at 161; *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 327-28 (2006). As described in Part I.A, *supra*, the obstacles imposed by H.B. 1510 place women at greater health risk by denying them vital information about the health consequences of their pregnancies.

As discussed, H.B. 1510 is unconstitutional without a balancing test because no state interest can justify a pre-viability ban. Nevertheless, the state argues that the ban serves its interest in women's health and potential life. Neither interest is served. The fifteen-week ban undermines women's health by forcing them to make decisions earlier, and forcing them to act without full information about their health

choices. As such, under the framework articulated in *Casey* and *Whole Woman's Health*, H.B. 1510 should additionally be invalidated as imposing an undue burden on women's right to access an abortion in a fully informed manner even prior to fifteen weeks.

II. The Ban Imposes Burdens on Women that Constitute Sex Discrimination in Violation of the Equal Protection Clause.

Mississippi's fifteen-week abortion ban also violates the Equal Protection Clause of the Fourteenth Amendment because it impermissibly advances stereotypes about women. The Court's abortion jurisprudence balances two interests: a woman's right to control her reproductive choices and a state's interest in potential life and women's health. *See Casey*, 505 U.S. at 898. When a state wishes to enact a restrictive abortion law, it emphasizes one of its own interests—that of potential life or the woman's health. Both the text of H.B. 1510 and Mississippi's defense of the law rely on the state's interest in potential life and women's health explicitly. *See* H.B. 1510 § 2; Br. for Defs.-Appellants at 35-36. But this argument can be used as a Trojan Horse, concealing a state's desire—often based on stereotypes that woman's destiny is to be a caregiver—to minimize women's interest in controlling their own reproductive choices. This is impermissible sex stereotyping, and can be illustrated in two clear ways. First, pre-viability abortion bans rely on stereotyping to box women both into a caregiving role and out of a breadwinning role. Second, Mississippi's stated interest in protecting potential life and women's health stands

in stark contrast with the state's other policies which demonstrate an inconsistent regard for infant and maternal health. The state's failure to serve its claimed interest in potential and infant life in other areas calls into question its claim that it restricts abortion because of its desire to protect potential life.

A. Mississippi's Fifteen-Week Ban Impermissibly Advances Unconstitutional Sex Stereotyping.

Laws that enforce sex-role stereotypes violate equal protection. *See Virginia*, 518 U.S. at 533 (holding that the state "must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females"); *Weinberger*, 420 U.S. at 645; *Frontiero v. Richardson*, 411 U.S. 677 (1973). Impermissible stereotypes of women include that "men are more likely than women to be the primary supporters of their spouses and children," *Weinberger*, 420 U.S. at 645, and that women are "the center of home and family life," *Califano v. Westcott*, 443 U.S. 76, 89 (1979); *see also Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1689 (2017) (rejecting "overbroad generalizations" that include the idea that "women are the 'center of home and family life'" (quoting *Hoyt v. Florida*, 368 U.S. 57, 62 (1961))). Historically, "mutually reinforcing stereotypes created a self-fulfilling cycle of discrimination that forced women to continue to assume the role of primary family caregiver." *Nev. Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003).

Pre-viability abortion bans rely on sex stereotyping to box women not just into a caregiving role—the "center of home and family life," *Califano*, 443 U.S at

89— but out of a breadwinning one. Thus begins a vicious circle: pre-viability bans on abortion are animated by sex stereotyping, and then further gender discriminatory outcomes that place women into gender-stereotyped roles.

First, this ban in effect forces women "to assume the role of primary family caregiver," and stereotypes women as destined to be caregivers. *Hibbs*, 538 U.S. at 736. By banning abortion before viability, the state is forcing some women to have children, when they would otherwise choose not to. The District Court decision affirms that this ban is motivated by a desire to "control[] women," noting that, until a few decades ago, Mississippi barred women from serving on juries so that they could "continue their service as mothers, wives, and homemakers." *Jackson Women's Health Org.*, 349 F. Supp. 3d at 541 n.22 (quoting *State v. Hall*, 187 So.2d 861, 863 (Miss. 1966)). Indeed, the ban consistently refers to patients at even the earliest stages of pregnancy as "maternal patient[s]" or even "mother[s]." *See, e.g.*, H.B. 1510, § 1(4)(a), (c), (d).

Second, women face "denial or curtailment" of employment opportunities due to the "pervasive presumption that women are mothers first, and workers second." *Hibbs*, 538 U.S. at 736 (citations omitted). "This prevailing ideology about women's roles has in turn justified discrimination against women when they are mothers or mothers-to-be." *Id.* (citations omitted). This is particularly true of pregnant women. Supreme Court jurisprudence on abortion recognizes that denying a woman the

opportunity to decide whether to become a mother has a direct impact on her economic life. *Casey*, 505 U.S. at 856. ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."). Yet the Mississippi legislature did not consider the effect of pregnancy on women's ability to secure employment, despite overwhelming evidence that pregnancy discrimination in the workplace poses an enormous challenge to women.[26]

The expectation that women are "mothers first, and workers second," *Hibbs,* 538 U.S. at 736, can yield acute harm when women are in fact both pregnant and the primary provider for themselves and their families. This can be true not only when a woman struggles to find employment due to pregnancy discrimination, but also in cases where pregnancy complications keep a woman from working. In these situations, women face uniquely limited options and navigate a world of unequal alternatives: a woman with severe preeclampsia or gestational diabetes may not only find herself unable to work and unable to seek an abortion, but also unable to seek

[26] *See* Jennifer Cunningham & Therese Macan*, Effects of Applicant Pregnancy on Hiring Decisions and Interview Ratings*, 57(7) SEX ROLES 497, 504 ("[I]n spite of being viewed as equally qualified, committed, dependable, and a fit for the position, the pregnant applicant received significantly lower hiring recommendations.").

disability benefits because pregnancy complications are often considered "short-term."[27]

Under no circumstances does the state make it a crime for a man to seek a treatment that could cure his disability, while simultaneously denying him access to disability benefits. This is because underlying the crosscutting policies that deny women an abortion that could cure their disability *and* deny them support during a pregnancy that renders them unable to work is the idea that women are destined for caregiving, but not for working outside the home. Such sex-based stereotyping is unconstitutional. *See Weinberger*, 420 U.S. at 645 ("Obviously, the notion that men are more likely than women to be the primary supporters of their spouses and children is not entirely without empirical support. But such a gender-based generalization cannot suffice to justify the denigration of the efforts of women who do work and whose earnings contribute significantly to their families' support." (internal citations omitted)); *Hibbs*, 538 U.S. at 731 (holding that pregnancy classifications that rest on the pervasive sex-role stereotype that caring for family members is women's work are in violation of constitutional equal protection guarantees).

[27] *See* Scott Flexer, *Can Pregnancy Really Qualify You For Disability?*, DISABILITY EXPERTS OF FLORIDA (June 30, 2015), https://www.disabilityexpertsfl.com/blog/bid/168345/Can-Pregnancy-Really-Qualify-You-for-Disability.

B. Mississippi's Stated Interest in Protecting Fetal Life and Maternal Health Cannot Justify this Ban.

The State asserts that the ban can be justified by its interest in protecting potential life and women's health. It cannot. "[T]he mere recitation of a benign . . . purpose is not an automatic shield which protects against any inquiry into the actual purposes underlying a statutory scheme." *Weinberger*, 420 U.S. at 648.

Mississippi's stated interest in protecting potential life and women's health stands in stark contrast with the state's other policies which demonstrate a disregard for infant and maternal health. The state's failure to serve its claimed interest in potential and infant life in other areas calls into question its claim that it restricts abortion because of its desire to protect potential life.

Mississippi has the highest infant mortality rate in the country.[28] In fifteen Mississippi counties, the infant mortality rate is over 12.4 per 1,000 live births[29]—more than twice the national average. This makes Mississippi's infant mortality rate higher than 110 different countries, including Libya, Albania, and Mexico.[30] The state also has the highest rates for low birth weight and preterm birth.[31] Nearly one

[28] *See* Centers for Disease Control and Prevention, *Infant Mortality Rates by State* (Jan. 15, 2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.
[29] *See* Mississippi State Department of Health, Office of Health Data and Research, *Infant Mortality Report 2017* at 2 (2017), https://msdh.ms.gov/msdhsite/_static/resources/7501.pdf.
[30] *See* Central Intelligence Agency, *Country Comparison: Infant Mortality Rate*, THE WORLD FACTBOOK (2017), https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091.rank.html.
[31] *See* Centers for Disease Control and Prevention, *Stats for the State of Mississippi* (Apr. 11, 2018), https://www.cdc.gov/nchs/pressroom/states/mississippi/mississippi.htm.

in seven infants in Mississippi is born preterm, and this number has been increasing.[32]

Similarly, Mississippi has one of the highest pregnancy-related maternal death rates in the U.S., more than twice the national rate: in 2010-2012, it was 39.7 deaths per 100,000 live births overall and 54.7 deaths per 100,000 live births among black women.[33] This is dramatically higher than the maternal mortality rates in most developed countries which range from 3 per 100,000 (Greece, Iceland, Poland, and Finland) to 14 per 100,000 (United States).[34]

Despite these dismal maternal and infant health outcomes, the state has nonetheless declined to take steps that could improve maternal and infant health. Mississippi has declined to expand Medicaid, which would provide increased access to healthcare to many low-income mothers and children. This is so despite the fact that Mississippi has the sixth highest percentage of uninsured residents out of all 50 states.[35]

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[32] *See Infant Mortality Report 2017*, *supra*, at 4.
[33] Mississippi State Department of Health, *Pregnancy-Related Maternal Mortality, Mississippi, 2011-2012* 1, http://msdh.ms.gov/msdhsite/_static/resources/5631.pdf (last visited Apr. 9, 2019).
[34] *See* Central Intelligence Agency, *Country Comparison: Maternal Mortality Rate*, THE WORLD FACTBOOK (2015), https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html.
[35] Centers for Disease Control and Prevention, *Uninsured at the Time of Interview for All Ages by State* (June 14, 2016), https://www.cdc.gov/nchs/pressroom/sosmap/nhis_insured/nhisuninsured.htm.

When women are asked about their reasons for deciding to end a pregnancy, forty percent or more cite financial reasons.[36] In fact, forty-nine percent of the women who choose to end pregnancies live below the federal poverty level, and seventy-five percent are poor or low-income.[37] Thirty-eight percent of women report that they decided to end a pregnancy because a pregnancy would interfere with their job, employment, or career.[38] The fear is well founded. Even with the protections of federal laws such as the Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e (2018), and the Family Medical Leave Act (FMLA) of 1993, 29 U.S.C. § 2601 (2018), pregnant women lose their jobs at a significant rate.[39] Nearly one-third of all claims alleging discriminatory discharge filed at the Equal Employment Opportunity Commission were filed by women alleging they were discharged for becoming pregnant.[40]

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[36] *See* M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN'S HEALTH 29 (2013) (employing data collected from 2008-2010); *cf*. Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. SEXUAL & REPROD. HEALTH 110-18 (2005) (describing a study that employed different questions and data from 2004 and found that 73% percent of women reported having an abortion because they could not afford having a baby).

[37] *See* Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST., 1, 11 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[38] *See* Finer et al., *supra*, at 113.

[39] See National Partnership for Women & Families, *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace, An Analysis of U.S. Equal Employment Opportunity Commission Charges (Fiscal Years 2011-2015)* (Oct. 2016), http://www.nationalpartnership.org/our-work/resources/workplace/pregnancy-discrimination/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf (analyzing the nearly 31,000 claims of pregnancy discrimination filed with the EEOC and state-level fair employment agencies between October 2011 and September 2015).

[40] *Id.*

Given the centrality of financial considerations in decisions about having children, a state that truly wanted to protect potential life and reduce abortions would provide additional economic support to women who want to carry a pregnancy to term but lack the resources to care for a (or another) child. At the very least, the state could provide job protections to pregnant women, requiring employers to make reasonable accommodations that would allow pregnant workers to keep their jobs. But Mississippi, unlike the substantial majority of states, including Louisiana and Tennessee, has no law that either prohibits private employers from discriminating against pregnant women or requires private employers to provide pregnancy accommodations.[41]

Mississippi's claimed interests in potential life and women's health—interests it is now claiming are so large as to warrant an abortion ban that is blatantly unconstitutional under *Casey*—are unconvincing in light of the state's evident failure to support prenatal and infant health. This further illustrates the point made above that the state is motivated by another interest—its interest in curtailing women's reproductive choices, which amounts to constitutionally impermissible discrimination.

[41] United States Department of Labor, *Employment Protections for Workers Who Are Pregnant or Nursing* (Oct. 2017), https://www.dol.gov/wb/maps/.

Nor does Mississippi take substantial steps to protect potential life by reducing the number of unwanted pregnancies and thus the number of abortions.[42] Unlike the majority of states, Mississippi does not require insurers to provide contraceptive coverage.[43] Mississippi also fails to adequately educate young people about how to avoid pregnancy, even though Mississippi has the third highest teen birth rates in the United States—more than one and a half times the national average.[44] Instead of teaching adolescents how to use contraception, Mississippi explicitly bans educators from showing students how to use contraceptives. *See* Miss. Code. Ann. § 37-13-171(2)(d) ("In no case shall the instruction or program include any demonstration of how condoms or other contraceptives are applied.").

The State's failure to serve its claimed interest in potential life in the areas outlined above and its failure to make policy choices that would reduce the need for abortions call into question its claim that it is restricting abortion out of concern for potential life. Mississippi is not protecting or expressing respect for potential life in

[42] Public health data demonstrates the relationship between improving contraceptive access and reducing abortions. Natalia Birgisson et al., *Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review*, 24 J. WOMEN'S HEALTH 349 (2015); Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291 (2012).

[43] Kaiser Family Foundation, *State Requirements for Insurance* (July 19, 2018), https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[44] Mississippi State Department of Health, *Personal Responsibility Education Program (PREP)*, (July 11, 2018), https://msdh.ms.gov/msdhsite/handlers/printcontent.cfm?ContentID=11790&ThisPageURL=http%3A%2F%2Fmsdh%2Ems%2Egov%2Fmsdhsite%2Findex%2Ecfm%2Findex%2Ecfm&EntryCode=11790&GroupID=44.

ways that many other states do. These state choices shape both the meaning and the effects of Mississippi's fifteen-week ban and undermine its claim that the law is designed to protect potential life and maternal health. Mississippi's contradictory behavior with respect to potential life, serving the interest only where a law restricts women's autonomy, demonstrates that other values reflecting views about women and appropriate sex roles are the true motivating factors behind its targeted regulation of abortion.

CONCLUSION

For the forgoing reasons, the District Court's decision should be affirmed.

Respectfully submitted,

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April 12, 2019

CERTIFICATE OF SERVICE

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

DATED: April 12, 2019

/s/ Priscilla J. Smith
Priscilla J. Smith

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Pursuant to Fed. R. App. P. 32(g), I hereby certify that this brief complies with the type-volume limitation and typeface requirements of Fed. R. App. P. 32, because it contains 6,376 words, excluding the portions of the brief exempted by Fed. R. App. P. 32(f), and has been prepared in a proportionally spaced typeface using Times New Roman 14-point font in Microsoft Word for Mac Version 16.23.

DATED: April 12, 2019

/s/ Priscilla J. Smith
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United States Court of Appeals

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April 15, 2019

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No. 18-60868
Jackson Women's Health Orgn, et al v. Thomas Dobbs, et al
USDC No. 3:18-CV-171

Dear Ms. Smith,

The following pertains to your brief electronically filed on April 12, 2019.

We filed your brief. However, you must make the following corrections within the next 14 days.

You need to correct or add:

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Mr. Christian Janet Strickland
Mr. Claude Szyfer

Case No. 18-60868

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