No. 20-5969

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH, et al.,

Plaintiffs-Appellees,

v.

HERBERT H. SLATERY, III, Attorney General of Tennessee, in his official capacity, et al.,

Defendants-Appellants.

On Appeal from the United States District Court for the Middle District of Tennessee, No. 3:20-cv-00501

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

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INTERESTS OF AMICI CURIAE

Amici States Illinois, California, Colorado, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia submit this brief, pursuant to Federal Rule of Appellate Procedure 29(a)(2), in support of plaintiffs-appellees. Tennessee's House Bill (H.B.) 2263 imposes two sets of bans on pre-viability abortion that threaten the health and welfare of Amici States' residents, who may need access to reproductive healthcare while visiting, studying, or working in Tennessee. The bans also affect physicians licensed in Amici States who practice medicine in Tennessee. *See, e.g.*, Zite Decl. ¶ 1, R.8-3, PageID#204 (physicians licensed in Illinois practice in Tennessee). Finally, the bans will cause Tennesseans to seek abortion care in Amici States—especially those near or neighboring Tennessee—which may place a strain on their healthcare systems.

INTRODUCTION

Reproductive healthcare allows women "to participate equally in the economic and social life of the Nation" and maintain control over their lives. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (plurality op.). Yet in June 2020, Tennessee passed H.B. 2263, enacting two sets of bans on pre-viability abortion. The first ban makes it a crime to perform an abortion as soon as a "fetal heartbeat" is detected—or as early as 6 weeks gestation—and then at various gestational intervals from 8 weeks through 24 weeks ("Cascading Bans"). Tenn. Code Ann. §§ 39-15-216(c)(1)-(12).[1] The second ban criminalizes performing abortions when the provider "knows" that the pregnant woman seeks to terminate a pregnancy "because of" the fetus' sex, race, or "a prenatal diagnosis, test, or screening indicating Down syndrome" ("Reason Ban") (together, the "Bans"). Tenn. Code. Ann. §§ 39-15-217(b)-(d). As plaintiffs explain, because the Bans prohibit women from exercising their right to obtain an abortion before viability, they are unconstitutional. *Casey*, 505 U.S. at 860.

[1] The Cascading Bans prohibit abortions after 6 weeks gestation, and if deemed unconstitutional, the weeks are extended to 8, 10, 12, 15, 18, 20, 21, 22, 23, and 24 weeks.

Amici States write separately to underscore that women's health is advanced by meaningful access to comprehensive reproductive healthcare services, including abortion. States can promote women's health by protecting women's constitutionally guaranteed right to access abortion. In fact, access to abortion care is integral to improving women's overall health outcomes. At the same time, Amici States are committed to affirming the dignity of all persons and protecting against discrimination on the basis of disability. Amici States thus ensure that women facing reproductive choices do not act on outdated information or harmful stereotypes about Down syndrome, yet do so in a manner consistent with their constitutional obligation to protect reproductive rights. Finally, in the Amici States' experience, criminalizing abortion, thereby eliminating or even reducing access to safe and legal abortion, leads to worse health outcomes for women and disproportionately harms women of color.

ARGUMENT

I. Tennessee's Prohibition Of Pre-Viability Abortion Is Unconstitutional.

The Supreme Court recognized in *Roe v. Wade*, 410 U.S. 113 (1973), that women have a constitutional right to choose an abortion before

viability. *Id.* at 163. In 1992, the Court reaffirmed this "essential holding," establishing that before viability, "the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846. Since then, this Court and the Supreme Court have repeatedly made clear that, "[b]efore viability, a State 'may not prohibit any woman from making the ultimate decision to terminate her pregnancy.'" *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (quoting *Casey*, 505 U.S. at 879); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2320 (2016) (citing "viability" as relevant point); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2135 (2020) (Roberts, J., concurring) ("*Casey* reaffirmed 'the most central principle of *Roe v. Wade*,' a woman's right to terminate her pregnancy before viability"); *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785, 795 (6th Cir. 2020) (statute criminalizing dilation and evacuation abortion after 11 weeks unconstitutional); *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 508 (6th Cir. 2006) (*Casey* reaffirmed that

"previability a woman has a right to obtain an abortion without the state imposing an undue burden on her decision").[2]

Tennessee's Bans are unconstitutional under this controlling precedent. The Cascading Bans prohibit women in Tennessee from obtaining an abortion at multiple gestational intervals, most of which occur several weeks before viability. *See* Norton Decl. ¶ 9, R.8-2, PageID##170-71 ("[n]o fetus is viable at the points in pregnancy when most of the Cascading Bans prohibit abortions"); *see also MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (viability is at "about 24 weeks"). Similarly, the Reason Ban criminalizes performing an abortion at any point prior to viability if the woman's choice is based on a reason disfavored by Tennessee lawmakers. The district court correctly enjoined these Bans as unconstitutional, and this Court should affirm.

[2] *See also Jackson Women's Health Organization v. Dobbs*, 945 F.3d 265, 271-74 (5th Cir. 2019) (15-week abortion ban unconstitutional); *Isaacson v. Horne*, 716 F.3d 1213, 1222-23, 1231 (9th Cir. 2013) (20-week ban unconstitutional); *Jane L. v. Bangerter*, 102 F.3d 1112, 1114, 1117-18 (10th Cir. 1996) (22-week (equivalent) ban unconstitutional).

II. Cutting Short The Period During Which Women Can Access Abortion Care Harms Women's Health.

Tennessee asserts that its Cascading Bans are aimed, in part, at protecting maternal health. Tenn. Code Ann. §§ 39-15-216, 217. But the Cascading Bans do not serve that purpose. The best way to advance women's health is to provide meaningful access to comprehensive reproductive healthcare services, including abortion.[3] 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."[4] In fact, abortion is markedly safer than childbirth.[5] Indeed, overwhelming scientific evidence establishes that highly restrictive abortion laws (like the

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[3] *Women's Health Policy in the United States: An American College of Physicians Position Paper*, 168 Ann. Intern. Med. 874, 876-77 (2018).

[4] *Am. Med. Ass'n v. Stenehjem*, No. 19-cv-125, (D.N.D. June 25, 2019), Complaint, Dkt. No. 1, at 5; *see Abortion Policy*, Am. Coll. of Obstetricians and Gynecologists (Nov. 2020), https://tinyurl.com/ACOG-Abortionpolicy. All websites were last visited on December 21, 2020.

[5] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety for Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215-19 (2012), https://tinyurl.com/Safety-of-Legal-Abortion.

Bans) lead to worse health outcomes.[6] For example, there is a direct connection between restrictive abortion laws and higher maternal mortality rates.[7] For this reason, many States have implemented a variety of programs and measures that promote women's healthcare but do not restrict a woman's constitutional right to choose what is right for her, her health, and her family.

A. The States' interest in promoting women's health is served by ensuring access to pre-viability abortion.

Barriers to abortion access cause a wide array of negative consequences. To begin, lack of access to abortion results in poorer socioeconomic outcomes, including lower rates of full-time employment and increased reliance on public programs.[8] Conversely, increased

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[6] *See* Guttmacher Inst., *Unintended Pregnancy and Abortion Worldwide* 2 (July 2020), https://bit.ly/3nz7qK8; Caitlin Gerdts, *et al.*, *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women's Health Issues 55, 58 (2016), https://tinyurl.com/y3yhv6ex.

[7] *See* Su Mon Latt, *et al.*, *Abortion Laws Reform May Reduce Maternal Mortality; An Ecological Study in 162 Countries*, 19 BMC Women's Health at 5, 8 (2019), https://tinyurl.com/BMCwomen-health (162-country study concluded that "maternal mortality is lower when abortion laws are less restrictive").

[8] Diana Greene Foster, *et al.*, *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United*

availability of abortion results in increased women's participation in the workforce, especially for women of color.[9]

Additionally, women forced to carry unwanted pregnancies to term risk more negative health outcomes, such as postpartum hemorrhage and eclampsia, and report a need to limit physical activity for a period three times longer than women who obtain abortions.[10] Women forced to carry a pregnancy to term also face increased risks of premature birth and low birth weight, congenital disorders, and schizophrenia in the child.[11] Moreover, carrying unwanted pregnancies to term can also result in a greater risk of domestic violence for women and their children, as having a child makes it harder to leave an abusive partner.[12]

States, 108 Am. J. Pub. Health 407, 409 (2018), https://tinyurl.com/yxw9rcdo.

[9] *See* Anna Bernstein, *et al.*, *The Economic Effects of Abortion Access: A Review of the Evidence*, Ctr. on the Econ. of Reprod. Health, Inst. for Women's Policy Research at v (2019), https://tinyurl.com/y3msrssg.

[10] Caitlin Gerdts, *et al.*, *supra* note 6.

[11] *Family Planning: Get the Facts About Pregnancy Spacing*, Mayo Clinic, (Feb. 5, 2020) https://tinyurl.com/y2zy24qj.

[12] Sarah C.M. Roberts, *et al.*, *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Medicine 1, 5 (2014), http://bit.ly/2J5nnJ3.

When States shorten the time in which women may exercise their right to obtain an abortion, these issues are exacerbated, especially among low-income women and women of color. *See, e.g.*, Grant Decl. ¶¶ 11, 17-18, R.8-6, PageID#260-61; Looney Decl., ¶¶ 30-32, R.8-1, PageID#148-49; Rovetti Decl. ¶¶ 17-21, R.8-4, PageID#242-43; Terrell Decl. ¶¶ 25-27, R.8-5, PageID#254-55. Many women will not learn they are pregnant early enough to seek abortion services, much less in time to comply with Tennessee's law, especially its 6-week Cascading Ban. Looney Decl. ¶ 26-28, R.8-1, PageID#147-48; Rovetti Decl. ¶ 14, R.8-4, PageID#241.

And those who are aware of their pregnancy may face obstacles to obtaining immediate care.[13] According to one study, the overwhelming majority of women who have an abortion in the second trimester "would

[13] The effects of the Bans are amplified by Tennessee's other obstacles to obtaining an abortion, such as (1) the mandatory 48-hour waiting period, requiring two separate trips to the clinic before obtaining an abortion, (2) the same-doctor requirement, making scheduled separate visits more challenging, and (3) the prohibition that precludes public insurance from covering abortion in nearly all circumstances. Tenn. Code Ann. § 39-15-202(a)-(h). *But see Adams & Boyle, P.C. v. Slatery*, No. 3:15-CV-00705, 2020 WL 6063778 (M.D. Tenn. Oct. 14, 2020) (enjoining the 48-hour waiting period), *appeal docketed*, *Bristol Reg'l Women's Ctr. v. Slatery*, No. 20-6267 (6th Cir. Nov. 6, 2020).

have preferred to have had their abortion earlier," but were unable to do so due to factors including cost and access barriers.[14] "In part because of their increased vulnerability to these barriers, low-income women and women of color are more likely to have second trimester abortions."[15] In addition, women who learn of fetal anomalies or develop complications relating to their own health during pregnancy will be disproportionately affected by the Cascading Bans, as many of these developments are detected during the second trimester.[16]

Added to these challenges is the lack of access to providers. It is already difficult to access abortion in much of the country, including Tennessee. In Tennessee, 96% of counties have no clinic that provides

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[14] Lawrence B. Finer, *et al.*, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 341 (2006), https://tinyurl.com/Delays-in-abortion.

[15] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009), http://bit.ly/3nCjZEq; *see also* Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12 PLOS ONE, 1 (2017), https://bit.ly/37AKvsm (finding higher likelihood of second-trimester abortion among women needing financial assistance to afford an abortion or those who live at least 25 miles from provider).

[16] Boaz Weisz, *et al.*, *Early Detection of Fetal Structural Abnormalities*, 10 Reproductive BioMedicine Online 541 (2005), https://bit.ly/37w55dn.

abortion, and 63% of Tennessee women live in those counties. Terrell Decl. ¶ 10, R.8-5, PageID#250 (only eight outpatient providers perform abortions in four cities in the State).[17] Although abortion is a "common medical procedure," given the lack of clinics, women must travel great lengths to get this often medically necessary and time sensitive healthcare.[18] In 2014, women in Tennessee had to travel a median distance of 26.91 miles to obtain an abortion, and some women traveled over 100 miles to reach the closest provider, which was across state lines.[19] Extensive travel for abortions is especially burdensome for those who rely on public transit, lack disposable income, or provide care to children or other dependents.[20] These reproductive healthcare

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[17] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Guttmacher Inst. 17 (2017), https://tinyurl.com/y7md8gtp.

[18] Alice F. Cartwright, *et al.*, *Identifying National Availability of Abortion Care and Distance from Major US Cities*, 20 J. Med. Internet Res. 1, (2018), https://www.jmir.org/2018/5/e186/.

[19] *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*, 2 The Lancet Pub. Health 493-99 (2017), http://bit.ly/3rfiNsU.

[20] Jenna Jerman, *et al.*, *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Perspective Sex Report of Health 2, 95-102 (2017), http://bit.ly/3hfBRD3.

"deserts" lead to the adverse consequences described above, including delays in care, negative mental health impacts, and consideration of self-induced abortion.[21]

B. States can promote women's health without curtailing the constitutional right to choose.

Amici States agree with Tennessee that States play an essential role in protecting and improving the health of women. Defs.' Br. 20, 51. In many circumstances, reasoned legislative judgments regarding healthcare should receive a substantial degree of respect from courts. No principle, however, requires or permits uncritical judicial acceptance of legislative judgments that improperly discount—or even countenance—increased risks to women's health. *See June Med. Servs.*, 140 S. Ct. at 2132-33; *Whole Woman's Health*, 136 S. Ct. at 2309-18; *Gonzales*, 550 U.S. at 165.

States can pursue a number of proven measures to advance women's health that do not include limiting abortion care. As one

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[21] Cartwright, *et al.*, *supra* note 18; Jerman, *et al.*, *supra* note 20; *see also Whole Woman's Health*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, at great risk to their health and safety.").

example, several Amici States maintain programs to increase access to contraception and family planning. In Illinois, a state program provides high-quality family-planning services to low-income individuals, thereby lowering the incidence of unintended pregnancies and sexually transmitted diseases; offers HIV testing and counseling; and oversees teen clinics.[22] Likewise, New Mexico's family-planning program offers clinical services including laboratory tests, counseling, and birth control, while supporting teen-oriented services like comprehensive sex education and adult-teen communication programs. In the same vein, Virginia promotes the health of families by providing family-planning services to allow families to control spacing between births and family size.[23] And a New York program provides low-income and uninsured individuals access to family-planning services.[24]

If a State's goal is to reduce the number of abortions, then increasing access to effective contraception "dramatically reduces

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[22] Ill. Dep't of Pub. Health, *Family Planning*, https://tinyurl.com/ybkhy69o.

[23] Va. Dep't of Health, *Family Planning*, http://bit.ly/34tJ0dA.

[24] N.Y. State Dep't of Health, *Comprehensive Family Planning and Reproductive Health Care Services Program*, https://tinyurl.com/y52lfpqa.

unwanted pregnancies and reduces the abortion rate."[25] Accordingly, certain Amici States have laws that require state-regulated health plans to cover all FDA-approved contraceptives for women without cost-sharing, *see, e.g.*, D.C. Code § 31-3834.03; N.Y. Insurance Law § 3221(*l*)(16), while others require this coverage for plans that maintain prescription benefits, *see* Nev. Rev. Stat. §§ 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, and 695C.1696. The use of contraception has averted a significant number of maternal deaths, primarily because contraception reduces the number of high-risk and high-parity births.[26] In short, by investing in family-planning services,

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[25] 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); *see also Priests for Life v. U.S. Dep't of Health and Human Services*, 808 F.3d 1, 22-23 (D.C. Cir. 2015) (Kavanaugh, J., dissenting) ("It is commonly accepted that reducing the number of unintended pregnancies would further women's health, advance women's personal and professional opportunities, reduce the number of abortions, and help break a cycle of poverty.").

[26] *See* Maternal Health Task Force, *Family Planning and Maternal Health*, Harvard Chan School Center of Excellence in Maternal and Child Health, http://bit.ly/3rdv8hn; Saifuddin Ahmed, *et al.*, *Maternal deaths averted by contraceptive use: an analysis of 172 countries*, 380 The Lancet 111-25 (2012), https://tinyurl.com/yyyxswzo.

Amici States have made significant strides in reducing maternal mortality rates and promoting women's health.[27]

Nevertheless, studies confirm that countries with restrictive abortion laws have worse health outcomes for women, including higher rates of maternal mortality.[28] Indeed, notwithstanding these state-led efforts, in the United States, more than 700 women die of pregnancy-related complications and more than 50,000 women experience a life-threatening complication every year.[29] Contributing to this crisis is Tennessee's own maternal mortality rate, which ranks among the worst in the country.[30]

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[27] *See e.g.*, Renee Montagne, *To Keep Women From Dying In Childbirth, Look To California*, Nat'l Pub. Radio (July 29, 2018), https://tinyurl.com/NPR-CAmaternalmortality; Let's Get Healthy California, *California's Infant Mortality Rate is Lower than the Nation's and Has Reached a Record Low*, https://tinyurl.com/GetHealthyCa.

[28] *See, e.g.*, Su Mon Latt, *et al.*, *supra* note 7.

[29] Michael C. Lu, *Reducing Maternal Mortality in the United States*, 320 JAMA 1237-38 (2018), https://bit.ly/3pcRMo3. Many of the States with the highest maternal death rates are States with restrictive abortion laws. *See* America's Health Rankings, *Health of Women and Children*, United Health Foundation, https://tinyurl.com/HealthRankings-AllStates.

[30] America's Health Rankings, *supra* note 29 at State Findings: Tennessee (2019), https://tinyurl.com/HealthRank-Tenn (in 2019, Tennessee ranked 41st in the country for maternal mortality); *see also*

Because pregnancies resulting in abortion are shorter than those where women are forced to carry to term, women who are able to obtain abortions face a decreased likelihood that pregnancy-related problems associated with maternal mortality will arise.[31] Indeed, access to early abortion avoids the "[m]any dangerous pregnancy-related complications such as pregnancy-induced hypertension and placental abnormalities manifest themselves in late pregnancy."[32] As the American College of Obstetricians and Gynecologists has reported, "[s]ince the early 1970s, the public health evidence has been made clear and incontrovertible: [legally] induced abortion is safer than childbirth," such that the risk of death increases 14-fold when women are forced to carry to term.[33] Ultimately, the risk of death will inevitably fall heaviest on young women, women of color, and those with little education and limited access to healthcare. *See infra* Section IV.

Anna Walton, *New Policy Brief asks: "Why are Tennessee moms and babies dying at such a high rate?"*, Georgetown University Health Policy Institute (Nov. 14, 2018), https://tinyurl.com/CCf-GWHealthPolicy.

[31] Raymond & Grimes, *supra* note 5.

[32] *Id.* at 217.

[33] *Id.* at 218.

In sum, the Cascading Bans will not advance maternal health, as Tennessee claims. Defs.' Br. 51. On the contrary, laws that thwart women's access to abortion, like the Cascading Bans, result in adverse health outcomes.

III. Dispelling Discriminatory Views About Persons With Disabilities Need Not Come At The Expense Of Reproductive Rights.

Amici States agree with Tennessee that States have a strong interest in combatting discrimination against persons with disabilities and in dispelling outdated and harmful views about disabilities, including Down syndrome. This interest, however, is insufficient to justify Tennessee's Reason Ban, which unlawfully interferes with reproductive autonomy.[34]

Dispelling discriminatory views about Down syndrome and protecting women's access to reproductive healthcare are not at odds. To the contrary, Amici States consistently exercise a range of options to

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[34] *See, e.g.*, *Planned Parenthood of Ind. and Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 888 F.3d 300, 306-07 (7th Cir. 2018), *cert. granted in part, judgment rev'd on other grounds sub. nom. Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780 (2019); *Little Rock Family Planning Servs. v. Rutledge*, 397 F. Supp. 3d 1213, 1271-72 (E.D. Ark. 2019), *appeal docketed*, No. 19-2690 (8th Cir. Aug. 9, 2019).

further the interests asserted by Tennessee without infringing on women's constitutional rights, including promoting accurate and non-biased information about Down syndrome, enforcing anti-discrimination laws, and providing supportive services for individuals with Down syndrome and their families. Protecting individuals with disabilities while simultaneously protecting women's reproductive rights furthers fundamental principles of autonomy and self-determination.

A. States have a range of tools to provide accurate, non-discriminatory information about developmental disabilities such as Down syndrome.

The district court's injunction does not leave States powerless to remedy alleged discrimination and misinformation about disabilities, as Tennessee suggests. Defs.' Br. 43, 47. States can and do promote the provision of medically accurate, unbiased information to help women make informed reproductive choices. States also support people with disabilities and their families by providing (and publicizing) civil rights protections and by delivering social and medical services.

Pro-information laws circulate accurate, non-biased information to dispel discriminatory stereotypes and prejudices regarding individuals with Down syndrome within the medical profession and society at large.

In 2008, Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act, which seeks to "coordinate the provision of, and access to, new or existing supportive services for patients receiving a positive diagnosis for Down syndrome." 42 U.S.C. § 280g-8(b)(1)(B). The law expanded the National Dissemination Center for Children with Disabilities, peer-support programs, adoption registries, awareness and education programs for healthcare providers, and the dissemination of information relating to Down syndrome. *Id.* § 280g-8(b)(1)(B)(ii)-(iv).

A number of Amici States have also passed their own pro-information laws.[35] These laws make evidence-based information about Down syndrome available to those who receive a prenatal indication of Down syndrome, including unbiased material on the outcomes, life expectancy, development, and treatment options for those with Down syndrome. Tennessee itself enacted such legislation, titled Down Syndrome Information Act, which became effective on July 1, 2018.[36]

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[35] *See* 410 Ill. Comp. Stat. 511/1; 16 Del. Code § 801B; Mass. Gen. Laws Ann. ch. 111, § 70H(b); Md. Code, Health-Gen. §§ 20-1501-1502; Minn. Stat. § 145.471; N.J. Stat. Ann. §§ 26:2-194, 26:2-195; 35 Pa. Stat. §§ 6241-44; Va. Code § 54.1-2403.1(B).

[36] *See* Tenn. Code Ann. § 68-1-1304.

These laws help healthcare providers transmit accurate, non-stigmatizing information, while leaving to women the ultimate decision of whether to terminate a pregnancy.

The National Down Syndrome Society, the leading human rights organization for individuals with Down syndrome, supports pro-information laws, explaining that, as a threshold matter, the decision "[w]hether to undergo prenatal testing must be solely that of the pregnant woman."[37] Once a woman decides to undergo prenatal testing, that testing "should be made available" because "[k]nowing in advance either the risk or diagnosis of Down syndrome can help parents educate, inform and prepare themselves for all issues regarding this genetic condition."[38] Furthermore, "[i]t is important that [families] receive accurate information and understand all [ ] options."[39] Upon learning about a diagnosis, some families begin "mak[ing] preparations (like informing other family members and doing research on Down

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[37] *NDSS Position Statement on Prenatal Testing*, https://tinyurl.com/NDSS-Position; *see also A Promising Future Together: A Guide for New and Expectant Parents*, National Down Syndrome Society at 7 (2015), https://tinyurl.com/GuidetoExpectant.

[38] *NDSS Position Statement*, *supra* note 37.

[39] *A Promising Future Together*, *supra* note 37.

syndrome) prior to the birth," while other parents "make arrangements for adoption," or plan to "discontinue their pregnancy."[40]

In addition, anti-discrimination laws and other civil rights laws enable States to both provide valuable legal protection to individuals with disabilities, and to fulfill the expressive function of law with a message of inclusion and respect. Just as the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.,* the Rehabilitation Act, 29 U.S.C. § 701 *et seq*., and the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 *et seq*., provide federal protections against discrimination for individuals with disabilities, States can—and do—enshrine similar protections in state law.[41]

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[40] *Id.*

[41] *See, e.g*., Cal. Civ. Code §§ 51, 54.1 (mandating "full and equal access" to public accommodations); Cal. Gov't Code §§ 12940, 12955 (prohibiting discrimination against individuals with disabilities in employment and housing); 775 Ill. Comp. Stat. 5/1-102 (prohibiting discrimination against disabled individuals in "employment, real estate transactions, access to financial credit, and the availability of public accommodations"); Conn. Gen. Stat. §§ 46a-60, 46a-64, 46a-64c and 46a70-76 (prohibiting discrimination based on intellectual disability in employment, public accommodations, housing, and state agency activities); Mass. Gen. Laws ch. 93, § 103 (protecting the right to equal participation in any program or activity within the Commonwealth); Mass. Gen. Laws ch. 151B, § 4 (prohibiting discrimination in

Another way to reduce bias and support individuals with Down syndrome is to offer supportive medical and social services.[42] Passage of the landmark Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 *et seq*., facilitated creation of such programs and helped lead society to have "greater faith in the competencies of citizens with [intellectual and developmental disabilities], and these citizens and their families [to] have higher expectations about the types of lives they will lead."[43]

Many States, too, have implemented supportive services. For example, California contracts with 21 nonprofit regional centers to provide services for people with developmental disabilities, ranging

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employment and housing); N.J. Stat. Ann. § 10:5-12 (prohibiting discrimination based on disability in employment, housing, and public accommodations); Or. Rev. Stat. § 659A.1112 (protecting persons with developmental disabilities from employment discrimination); 43 Pa. Stat. §§ 951-63; Va. Code §§ 51.5-1, 51.5 (establishes state policy and rights of individuals with disabilities).

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

[43] Nat'l Council on Disabilities, *Exploring New Paradigms for the Developmental Disabilities Assistance and Bill of Rights Act* 10 (2012), https://ncd.gov/publications/2012/Apr222012/intro.

from diagnosis and counseling to advocacy, family support, and planning care.[44] These centers provide in-home respite care, which is non-medical care that relieves families from providing constant care to a loved one with a developmental disability.[45] Connecticut's Department of Social Services helps individuals with developmental disabilities live in the community through a variety of community-based residential facilities. For instance, it established a Community Residential Facility Revolving Loan Fund for construction and renovation of community residences, supportive employment programs, including day care, recreation, and other services.[46]

Additionally, States' Medicaid programs can provide home and community-based services for persons with developmental disabilities.[47]

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[44] Cal. Dep't of Developmental Servs., *Regional Centers, Services Provided by Regional Centers*, https://www.dds.ca.gov/rc/.

[45] Cal. Dep't of Developmental Servs., *Respite (In-Home) Services*, https://tinyurl.com/yawuuspt.

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

[47] *See, e.g.*, Cal. Dep't of Health Care Servs., *Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD)*, https://tinyurl.com/yy74h6u7; Ill. Dep't of Human Servs., *Home-Based Support Services Overview*, http://bit.ly/3nzsKzm; Mass. Dep't of Developmental Servs., https://tinyurl.com/y8e4lvaf; N.M. Stat. Ann.

These services, which include access to skilled nurses, chore services, vehicle adaptations, and therapy, assist those with developmental disabilities in leading independent, productive lives. *See Ball v. Kasich*, 307 F. Supp. 3d 701, 707-08 (S.D. Ohio 2018) (noting States' shift toward community-based services led to increased satisfaction among individuals with disabilities and their families).[48]

Many Amici States also provide additional services and support specifically for new or expectant parents of a child with disabilities. For example, Massachusetts' Down Syndrome Congress is a statewide resource for Down syndrome information, advocacy, and networking.[49]

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§ 28-16A-1 *et seq*. (charging Department of Health to establish a Developmental Disabilities Planning Counsel to oversee provision of community-based services for people with developmental disabilities); N.Y. Dep't of Health, *Homes and Community-Based Services (HCBS) Waiver for Persons, Including Children, with Mental Retardation and/or Developmental Disabilities*, http://bit.ly/3rgI4Tx; Pa. Dep't Human Servs., *Home and Community-Based Services*, https://tinyurl.com/yc498y9d; Wash. State Dep't of Social & Health Servs., *Developmental Disabilities Admin.*, https://www.dshs.wa.gov/dda.

[48] *See supra* note 49; *see also* N.J. Stat. Ann. § 30:6D-12.1 *et seq*. (providing self-directed support services for persons with developmental disabilities).

[49] Commonwealth of Mass., *Understand Your Pediatric Patient's Down Syndrome Diagnosis*, https://tinyurl.com/y6l5tyrf; *see also* Wash. State

In addition to free resources, information, and training for potential parents, health professionals, educators, and the community at large, it also connects new or expectant parents who receive a diagnosis of Down syndrome with others facing similar life experiences through the Parents' First Call Program.

States have numerous tools to protect and improve the lives of persons with developmental disabilities, dispel outdated stereotypes and discrimination, and support families with disabled children. None of these efforts requires infringement on reproductive rights.

B. Eliminating disability discrimination and protecting access to reproductive healthcare are complementary objectives.

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

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Dep't of Health, *Down Syndrome: Information for Parents Who Have Received a Pre- or Postnatal Diagnosis of Down Syndrome*, https://tinyurl.com/y6zkt48j.

children with disabilities (when they do not want to do so) will fail to solve . . . broader stigma, and may even be counterproductive."[50] These concerns were echoed by disability rights leaders who joined an amicus brief in *Planned Parenthood of Indiana & Kentucky, Inc. v. Commissioner of Indiana State Department of Health*, opposing an Indiana law similar to Tennessee's Reason Ban.[51] They rejected the argument that state abortion bans are ethically necessary, arguing instead that ensuring the right to choose "empowers women and families who make the affirmative choice to see a pregnancy through to term" and "provides the greatest assurance that the mother and her family will be able to create and maintain an environment in which a disabled child is likely to thrive."[52]

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[50] Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 Harv. J. of L & Gender 425, 457-58 (2006).

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

[52] *Id.* at *4.

IV. Criminalizing Abortion Exacerbates Racial Inequities.

In enacting Reason Ban, the Tennessee legislature stated it acted in response to historic discriminatory practices against non-white individuals. *See generally* Tenn. Code Ann. § 39-15-214; Defs.' Br. 13. But contrary to Tennessee's assertion that its laws thwart racial discrimination, Defs.' Br. 13, the Bans will likely cause *more* harm to women of color who are forced to carry to term.

First, limiting access to safe and legal abortion harms racial minorities because women of color are disproportionately represented in maternal mortality rates in Tennessee. As discussed, *see supra* Section II, restrictive abortion laws cause worse health outcomes for women, and lead to higher rates of maternal mortality. In Tennessee, Black women in particular bear those burdens. The Tennessee Department of Health found that, in 2018, Black women were three times more likely to die from a pregnancy-related complication than white women.[53] Ensuring that women have access to safe and legal abortion leads to better health outcomes for women at large, but is particularly beneficial

[53] Tenn. Dep't of Health, *2020 Tennessee Maternal Mortality Annual Report* 6-7 (2020), https://tinyurl.com/y228ql9k.

for women of color who are disproportionately represented in Tennessee's increasing maternal mortality rates.

Second, a State's failure to support the health of women through programs such as Medicaid has a discriminatory impact on women of color, particularly when coupled with highly restrictive abortion laws. Tennessee's decision to restrict access to healthcare—for example, by declining to expand Medicaid—thus only exacerbates these discriminatory effects. By contrast, as described, Amici States have promoted women's health by expanding access to healthcare services and contraceptives, supporting maternal and infant healthcare programs, and offering educational and counseling services. Many States have also extended healthcare to millions of women by expanding Medicaid for childless adults with incomes up to 138% of the federal poverty line. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i).[54] To date, 39 States and the District of Columbia, have expanded Medicaid, resulting in approximately 12.7 million

[54] Kaiser Family Found., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (July 14, 2020), http://bit.ly/3pbjdiq (103,000 individuals would become eligible for healthcare coverage if Tennessee expanded Medicaid).

additional Americans receiving health coverage.[55] Those covered now include significantly more low-income women of reproductive age, particularly Black women, which contributes to the reduction of the large racial disparity in maternal mortality.[56] And ongoing research confirms that the "maternal mortality ratio is lower in States that have adopted Medicaid expansion compared to non-expansion States."[57]

In States that have not expanded Medicaid, however, uninsured women become eligible for coverage only while pregnant, with coverage ending 60 days after delivery.[58] This limited coverage period results in postpartum gaps in care, leaving women at risk of higher morbidity and mortality rates during the critical six-month period following birth.

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[55] *See* Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision* (updated Oct. 16, 2020), https://tinyurl.com/KKF-Medicaid-Expansion.

[56] *See* Emily M. Johnston, *et al.*, *Impacts of the Affordable Care Act's Medicaid Expansion on Women of Reproductive Age*, 28 Women's Health Issues 122-129 (2018), https://tinyurl.com/y4pf8prg (Medicaid expansions decreased the uninsurance rate among low-income women of reproductive age by 13.2%); Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Mortality*, 30 Women's Health Issues 147-52 (2020), https://bit.ly/37EeQ9H.

[57] Sarah H. Gordon, *et al.*, *Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization*, 39 Health Affairs 1 (2020), https://tinyurl.com/HealthAff-MedExp.

[58] *See* Johnston, *et al.*, *supra* note 58 at 123.

And as the data reflects, in Tennessee, those maternal mortality risks are shouldered disproportionately by Black women. Tennessee's decision to maintain those coverage gaps by failing to expand Medicaid serves only to exacerbate the discriminatory effects of restrictive abortion laws like H.B. 2263, undermining its claim that the Bans are necessary to combat racial discrimination.

CONCLUSION

The district court's order entering preliminary injunctive relief should be affirmed.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(a)(4)(G) and 32(g), I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(C) because it contains 5,660 words, excluding the parts of the brief exempted by Fed. R. App. P. 29(a)(5) and 32(a)(7).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in 14-point Century Schoolbook using Microsoft Word.

Dated: December 22, 2020 /s/ Sarah A. Hunger

CERTIFICATE OF SERVICE

I certify that on December 22, 2020, I electronically filed the foregoing Brief of Amici Curiae Illinois, *et al.*, with the Clerk of the Court of the United States Court of Appeals for the Sixth Circuit by using the CM/ECF system. I further certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: December 22, 2020 /s/ Sarah A. Hunger