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
Middle District of Tennessee, Nashville Division
No. 3:20-cv-00501

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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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

First, the District Court properly found that HB 2263 ("the Act"),[3] including its Cascading Bans and its Reason Bans,[4] runs afoul of Supreme Court

[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. 2263, 111th Gen. Assemb., 2020 Sess. (Tenn. 2020) (enacted), *codified at* Tenn. Code. Ann. §§ 39-15-214 to -218.

[4] The Amicus adopts the Plaintiffs-Appellees' description of the Act and its prohibitions—the "Cascading Bans" and the "Reason Bans"—included in its Brief. *See* Brief of Plaintiffs-Appellees, ECF No. 39, at 4 (Dec. 15, 2020) ("Pls.' Br.").

jurisprudence by prohibiting pre-viability abortions. *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-CV-00501, 2020 WL 4274198 (M.D. Tenn. July 24, 2020). The Supreme Court has reaffirmed numerous times over nearly fifty years that no interest justifies prohibiting women from obtaining previability abortions—not at any point previability and not for any reason. *Thus ends this case*.

Second, even if the Act were not a ban on previability abortions, it would fall because it fails to serve and in fact works against any valid interests in women's health or potential life. The Act completely disregards the emphasis in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), on the provision of full information to a pregnant woman considering her options. Especially important to a woman's choice is information about the potential risks of pregnancy and abortion. Pregnancy can seriously exacerbate preexisting medical conditions, and can cause unanticipated complications of individual pregnancies. These health risks usually emerge well after six weeks of pregnancy, and can arise throughout the second trimester. The Cascading Bans would force women to decide to have an abortion before they can know the effect of the pregnancy on their health. They do not promote women's health; they jeopardize it.

Similarly, by denying women full access to information about their health, the Bans fail to serve any valid interest in potential life. The means of such regulations chosen by the State "must be calculated to inform the woman's free

choice, not hinder it." *Casey*, 505 U.S. at 877. Ironically, the Bans can also actually work against any valid interest in potential life by increasing abortions among women at higher than average risk of complications. Some of these women accept the risk of a continuing pregnancy only because they know abortion is available if their health were to deteriorate.

Finally, despite the bedrock principle that previability abortions cannot be prohibited for any reason, Tennessee still attempts to justify the Bans as health and life-protective. *See* Tenn. Code. Ann. § 39-15-214. But Tennessee's policy choices belie its claims. Tennessee has spurned policies—policies that most other states have adopted—that would support women with wanted pregnancies, improve access to quality health care, decrease abortion rates, and improve the State's devastating rates of infant and pregnancy-caused deaths. Instead, Tennessee adopted the Bans, endangering women's health, and pressuring or forcing women to give birth in a state with the seventh-highest pregnancy-related death rate out of states with measurable data, the ninth-highest infant death rate in the nation, and the tenth-highest rates of preterm birth and low birth weight. *See infra* § III.A. These contradictory policy choices—obstruction of abortion on the one hand and neglect of women who want to carry to term and their infants on the other—show

that opposition to abortion does not always come from a "pro-life" or a pro woman's health impulse.[5]

ARGUMENT

I. The Act Flouts Fifty Years of Jurisprudence Protecting a Woman's Absolute Right to Terminate Her Pregnancy Prior to Fetal Viability.

The Court has drawn a line in the sand, a line considered the "central principle" of *Roe*, a line repeatedly reaffirmed for nearly half a century: no state interest—not an interest in women's health, potential fetal life, or any other interest the state claims—can justify prohibitions on previability abortion. *See Roe v. Wade*, 410 U.S. 113 (1972); *Casey*, 505 U.S. at 879; *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292 (2016); *June Med. Servs. v. Russo*, 140 S. Ct. 2103, 2135 (2020) (Roberts, C.J., concurring) Pls.' Br. at 16-25. The Cascading Bans and the Reason Bans at issue here fall under the weight of this precedent. *End of story. End of case.*

II. The Arbitrary Cutoffs Imposed by The Cascading Bans Force Women to Choose Abortion Care or to Continue Their Pregnancies to Term Before Being Fully Informed About Their Health Risks.

Because the Act violates the principle at the heart of abortion jurisprudence, this Court need not evaluate whether the Act actually serves interests that could in

[5] *See* Reva B. Siegel, *ProChoiceLife: Asking Who Protects Life and How—Why it Matters in Law and Politics*, 93 IND. L.J. 207, 216 & n.35 (2018).

other circumstances justify regulation of the provision of abortions.[6] It bears noting, however, that despite Tennessee's claim that the Bans are health-protective and life-protective, *cf.* Tenn. Code. Ann. § 39-15-214(b)(1) (claiming that the law serves both interests), the Act is neither. In fact, it works against both interests.

Central to *Casey*'s vision is the idea that adequate information is essential to the woman's "effective right to elect" an abortion. 505 U.S. at 846. Provision of full information protects a woman's health and is also the means by which the state may express its preference for childbirth over abortion with the hope that a woman may decide to carry her pregnancy to term. *Casey* is clear, however, that the means chosen by the State "*must be calculated to inform the woman's free choice*, not hinder it," and must "ensure that the woman's choice is informed." *Id.* at 877-78 (emphasis added). In particular, there is a "substantial government interest justifying a requirement that a woman be apprised of the health risks of abortion *and childbirth*." *Id.* at 882 (emphasis added).

The Act deprives women of two types of health information. First, pregnancy often exacerbates chronic medical conditions in ways that impose additional risks to the health of the pregnant woman.[7] Women with these conditions may attempt to carry to term by safely managing the condition, but they

[6] *Compare Casey*, 505 U.S. at 898; *Whole Woman's Health*, 136 S.Ct. 2292.
[7] *See generally* F. Gary Cunningham et al., WILLIAMS OBSTETRICS (20th ed. 1997).

and their loved ones sometimes choose this option *only because* women retain the option to terminate if their health deteriorates. The Act's Cascading Bans prevent women from waiting to see if their condition worsens during pregnancy. If they learn they are pregnant before the gestational limit of the Cascading Ban in effect at the time, they must either terminate their pregnancy right away to protect their health, or place themselves at a higher risk for severe complications and even death if their condition worsens as the pregnancy progresses.

For example, a woman with preexisting hypertension is at a higher risk of developing preeclampsia, a complication of pregnancy that affects various vital organs.[8] 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.[9] Preeclampsia typically does not develop until at least the second trimester, and termination of the pregnancy, either by abortion or delivery depending on the point in pregnancy, is typically the treatment recommendation for moderate or severe preeclampsia that does not improve with hospitalization.[10] Similarly, when a woman is suffering from pulmonary hypertension during the

[8] Noura Al-Jameil et al., *A Brief Overview of Preeclampsia*, 6 J. CLINICAL MED. RES. 1, 1 (2014).
[9] *Id.*
[10] Cunningham et al., *supra* note 7, at 717.

second trimester, when a fetus is not yet viable, the best treatment option may be abortion.[11]

Diabetes is another chronic condition that can worsen significantly during pregnancy. Even when pregnant diabetic women's condition is carefully managed, they are at significant risk for developing hypoglycemia.[12] This dangerous condition increases the likelihood that a woman will suffer severe complications including seizures, blindness, and diabetic coma.[13] Gestational diabetes, with the same significant risks, manifests only during pregnancy, and screening for the condition typically does not occur until twenty-four to twenty-eight weeks' gestation.[14]

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

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[11] 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).
[12] Gita Shafiee et al., *The Importance of Hypoglycemia in Diabetic Patients*, 11 J. DIABETES & METABOLIC DISORDERS 17, 19 (2012).
[13] *Id.* at 17.
[14] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *Gestational Diabetes* (Nov. 2017), https://www.acog.org/Patients/FAQs/Gestational-Diabetes .
[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).

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] The Act 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.

Second, in addition to chronic conditions that worsen during pregnancy, a number of conditions manifest only in the second or third trimester, meaning that a pregnant woman will not have information relevant to her decision if she is forced to choose an abortion before or during the second trimester, depending on which Cascading Ban is in effect. 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

[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* Cunningham, *supra* note 7, *Section X: Common Complications of Pregnancy*, at 693-894.

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 lethal fetal anomalies.[20] As with other conditions, it is almost impossible for women to be adequately aware of these risks at the outset of pregnancy, as genetic screenings are only able to diagnose certain physical anomalies and chromosomal abnormalities during the second trimester.[21]

The Act's limited (and unconstitutionally vague)[22] medical emergency exception does not adequately address these concerns; it actually further illustrates them. It requires a woman's medical complication to deteriorate so much that it "necessitate[s] the *immediate* performance or inducement of an abortion . . . to prevent the death . . . or avoid a serious risk of [a] substantial and irreversible impairment," of the pregnant woman, forcing physicians to wait until their patients

[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] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *Prenatal Genetic Diagnostic Tests* (Jan. 2019), https://www.acog.org/Patients/FAQs/Prenatal-Genetic-Diagnostic-Tests.
[22] *See* Pls.' Br. at 3-4 (discussing *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997)).

are gravely ill—on the verge of dying—before providing abortion care.[23] *See* Tenn. Code. Ann. § 39-15-216(e); *id.*§ 39-15-211(a)(3).

III. Tennessee's Policy Choices—as Contrasted with Comparator States Nationwide—Reflect an Anti-Abortion Bias, Not an Impulse to Promote Women's Health or a Valid Interest in Potential Life.

As shown above, the Act will never protect women's health; it will only jeopardize it, placing women at risk of death and significant health impairments. And it cannot serve a valid fetal life interest—an interest in *informing*, *not hindering* a pregnant woman's free choice—because it strips women of the right to make a choice altogether.

But there is another reason to doubt the sincerity of Tennessee's claimed state interests. Tennessee's purported concern for potential fetal life and women's health is belied by its failure to address its maternal and infant mortality crisis, and its failure to reduce abortions through means that do not rob women of control over their own decisions and bodies.

A. Tennessee Suffers Some of the Highest Rates of Infant Mortality and Deaths of Women from Pregnancy-Related Causes in the Country.

According to the Centers for Disease Control and Prevention ("CDC"), approximately seven infants die out of every 1,000 live births in Tennessee, the

[23] *See* Pls.' Br. at 8 (citing Zite Decl. ¶¶ 17-22, R.8-3, Page ID ##208-10).

ninth-highest infant mortality rate in the country,[24] and a rate that exceeds the national average of 5.8 by 21%.[25] Two counties in Tennessee report infant mortality rates over 20 per 1000—a shocking one death for every fifty births. And the racial disparities in infant mortality data paint an even starker picture. The statewide rate is almost twice as high for Black infants (11 per 1,000 live births) than for white infants (5.8 per 1,000 live births).[26] The State also ranks in the top ten states for rates of preterm, low birthweight, and teen births.[27]

The conditions for pregnant women are similarly dire. Tennessee has the seventh-highest pregnancy-related death rate in the U.S. among states with measurable data; 26 women died from pregnancy-related causes per 100,000 live births in 2018, compared to a national rate of 17.4 per 100,000.[28] Again, the racial disparities are expecially shocking. In Tennessee, the rate of pregnancy-related

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[24] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *Infant Mortality Rates by State* (Jan. 15, 2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm; *see also* TENN. DEPT. OF HEALTH, *2017 Child Fatality Annual Report*, at 80-82 (2017), https://www.tn.gov/content/dam/tn/health/documents/2017_CFR_Annual_Report,_Final.pdf.

[25] TENN. DEPT. OF HEALTH, *supra* note 24, at viii.

[26] *Id.*, at ix, 80-82.

[27] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *Stats for the State of Tennessee* (Apr. 9, 2018), https://www.cdc.gov/nchs/pressroom/states/tennessee/tennessee.htm.

[28] CTRS. FOR DISEASE CONTROL & PREVENTION, *Maternal Mortality by State, 2018* (2018), https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf.

deaths is more than twice as high for Black women (38.2 per 100,000 live births) than for white women (20.8 per 100,000).[29] Pregnant women in Tennesee die from pregnancy-related causes at a rate more than *ten times* that in countries like Italy, Norway, and Poland.[30]

B. Tennessee Failed to Adopt Policies to Support Women Who Want to Carry Pregnancies to Term.

Tennessee had at its disposal, and yet failed to adopt, several legislative tools to support pregnant women trying to carry to term. First, Tennessee has failed adequately to address the most commonly cited reason that women give when they explain their decision to have an abortion: lack of financial support.[31] In 2014, three-fourths of abortion patients nationwide were low-income. Forty-two percent (42%) of women having abortions subsisted at or below the federal poverty level and another twenty-seven percent (27%) had incomes at or below 200% of the

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[29] *See* TENN. COMM'N ON CHILDREN & YOUTH, *The State of the Child in Tennessee* at 14 (2019), https://www.tn.gov/content/dam/tn/tccy/documents/kc/tccy-kcsoc/kcsoc19.pdf.

[30] *See* Central Intelligence Agency, *Country Comparison: Maternal Mortality Rate*, THE WORLD FACTBOOK (2017), https://www.cia.gov/library/publications/the-world-factbook/fields/353rank.html.

[31] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN'S HEALTH, at 5 (2013) (40% of women cite financial reasons for seeking an abortion; 6% of women say that financial reasons are their *only reason* for seeking abortion); *see also* Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPS. ON SEXUAL & REPROD. HEALTH 110, 112 (2005) (discussing study finding 73% percent of women reported having an abortion because they could not afford having a baby).

poverty level.[32] Given the centrality of financial considerations in abortion decisions, a state that truly wanted to protect potential life and reduce abortions would provide women the economic support to carry a pregnancy to term. However, the maximum monthly benefit for a family of three (one parent and two children) in Tennessee is $185 per month, while the median monthly cash assistance benefit nationwide is $450.[33] This level of financial assistance is nowhere near sufficient to meet a family's basic needs.

While Tennessee ha*s* provided some additional health care coverage for pregnant women to cover those at up to 200% of the federal poverty line,[34] it is one of only twelve states in the nation that have chosen not to expand Medicaid eligiblity overall to 138% of the poverty line, despite the availability of significant federal matching funds.[35] Once a pregnant woman gives birth, she will lose her Medicaid coverage unless her income is below 94% of poverty.[36]

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[32] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* at 6, GUTTMACHER INST. (2016), https://bit.ly/2R7WGVL.

[33] Bejamin Goehring et al., WELFARE RULES DATABOOK: STATE TANF POLICIES AS OF JULY 2018 at 117-19, ADMIN. CHILDREN & FAMILIES, U.S. DEP'T HEALTH & HUMAN SERVS. (Aug. 2019), https://bit.ly/2L9YU3h.

[34] KAISER FAMILY FOUNDATION, *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level,* (Jan. 1, 2020), https://bit.ly/38mrWaA.

[35] A full sixty-one percent (61%) of Tennessee's Medicaid costs, including for this Medicaid expansion, are covered by the federal government, the sixteenth-highest rate in the country. KAISER FAMILY FOUNDATION, *Federal Medical Assistance*

States that have adopted the expansion include states with higher rates of people living in poverty than Tennessee—like Louisiana, Arkansas, Kentucky and West Virginia. Notably, Tennessee ranks much higher in terms of fiscal solvency than these other states. In fact, Tennessee is the *third most solvent* state in the country; Arkansas is the twenty-fifth, Louisiana the thirty-seventh, West Virginia the forty-third, and Kentucky the forty-sixth.[37]

C. Tennessee Has Not Chosen to Reduce Abortions and Improve Women's Health by Reducing Unintended Pregnancies.

Numerous studies concur that access to effective contraception dramatically reduces unintended pregnancies and thereby cuts abortion rates.[38] However, Tennessee has not worked to ensure access. Unlike the majority of states, Tennessee does not require insurers to provide contraceptive coverage.[39]

Percentage (FMAP) for Medicaid and Multiplier (FY 2021), https://bit.ly/3h9VpZ8.

[36] KAISER FAMILY FOUNDATION, *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level* (Jan. 1, 2020), https://bit.ly/3ruWi3w.

[37] MERCATUS CTR. AT GEORGE MASON UNIV., *State Fiscal Rankings* (Oct. 9, 2018), https://www.mercatus.org/publications/urban-economics/state-fiscal-rankings.

[38] Public health data demonstrates the relationship between improving contraceptive access and reducing abortions. *See, e.g.*, 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).

[39] KAISER FAMILY FOUNDATION, *State Requirements for Insurance* (July 19, 2018), https://bit.ly/34Cjv9X.

Moreover, although Tennessee is in the top ten states for teen births,[40] Tennessee requires educators to promote abstinence-only pregnancy avoidance, instead of requiring that adolescents be taught how to use effective contraception. *See* Tenn. Code. Ann. § 49-6-1304 (requiring educators to "emphatically promote only sexual risk avoidance through abstinence.").

In sum, Tennessee has rejected myriad policies adopted by comparable states to support maternal and infant health and reduce abortions through means that enhance women's reproductive autonomy. Instead, Tennessee has opted to obstruct abortion access, limit women's health care options, and neglect families' medical and health care needs. Taken together, these choices demonstrate pure hostility to abortion, rather than any genuine dedication to women's health or potential life.

CONCLUSION

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

Respectfully submitted,

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December 22, 2020

[40] CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 27.

CERTIFICATE OF COMPLIANCE

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 3,458 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 14.7.7.

DATED: December 22, 2020

/s/ Priscilla J. Smith
Priscilla J. Smith

CERTIFICATE OF SERVICE

I hereby certify that on December 22, 2020 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: December 22, 2020

/s/ Priscilla J. Smith
Priscilla J. Smith