No. 17-935

IN THE

# Supreme Court of the United States

PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, *et al.*,

*Petitioners*,

—v.—

LARRY JEGLEY, *et al.*,

*Respondents*.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

## BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND AMERICAN PUBLIC HEALTH ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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## INTEREST OF *AMICI CURIAE*

*Amici curiae* the American College of Obstetricians and Gynecologists ("ACOG") and the American Public Health Association ("APHA") submit this brief in support of Planned Parenthood of Arkansas & Eastern Oklahoma, d/b/a Planned Parenthood Great Plains, and Dr. Stephanie Ho, M.D. ("Petitioners").[1]

ACOG is a national non-profit educational and professional organization dedicated to advancing women's health care. As a voluntary membership organization for obstetrician-gynecologists and other women's health care providers, ACOG has more than 58,000 members, including 322 in Arkansas. ACOG develops and publishes evidence-based practice guidelines, maintains the highest standards for continuing medical education, promotes high ethical standards, and fosters contributions to medical and scientific literature across all mediums and for all aspects of women's health.

ACOG recognizes that abortion is an essential health care service and opposes laws affecting health

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[1] No counsel for a party authored this brief in whole or in part and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person or entity other than *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for the parties received timely notice of the intent to file this brief in accordance with Rule 37 of the Rules of the Supreme Court of the United States. Emails from the parties granting consent to the filing of this brief are on file with the Clerk of the Court.

care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

ACOG's work has been cited by numerous courts seeking authoritative medical data regarding childbirth and abortion.

APHA is an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research. APHA combines a 140-plus-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

APHA has over 20,000 members, 82 of whom reside in Arkansas, and has also maintained a connection to the public health community in Arkansas through its affiliate, the Arkansas Public Health Association, which has provided nearly 69 years of public health service. With a membership of about 456, the Arkansas Public Health Association serves Arkansas residents by supporting a scientifically-based public health approach and advocating for important public health issues impacting Arkansans.

APHA and ACOG have long recognized that access to the full range of reproductive health services, including abortion, is a fundamental right integral both to the health and well-being of individual women and to the broader public health. APHA and ACOG oppose restrictions that deny,

delay, or impede access to abortion services and that coerce women to carry unintended pregnancies to term. APHA and ACOG have previously appeared as *amicus curiae* in various courts on matters relating to reproductive health, including in the Eighth Circuit below, and in this Court.

## SUMMARY OF ARGUMENT

Reproductive health care is essential to a woman's overall health, and access to abortion is an important component of reproductive health care. When legislatures enact laws that restrict access to abortion without any valid medical justification, they jeopardize women's health.

Passed in 2015, Arkansas Act 577, Ark. Code Ann. § 20-16-1501 *et seq.* (2016) (the "Act") requires any physician who administers medication abortions to contract with a physician with active admitting privileges at a hospital (the "contracted physician requirement"). It imposes this requirement without regard to the many reasons, unrelated to a physician's technical competence or patient health, that can make it difficult or impossible to enter into such a contract.

The contracted physician requirement runs contrary to accepted medical practice and is not based on scientific evidence. It does not improve the quality or safety of abortion-related medical care and, in fact, impedes women's access to such care. Indeed, the contracted physician requirement would force two of the three legal abortion providers in Arkansas to stop providing abortion services. What is more, the Act would eliminate medication abortion in the

state entirely, even though that procedure is preferred by, or medically-indicated for, a substantial number of women. Accordingly, without this Court's review, the Act would deprive women in Arkansas of quality, evidence-based medical care and their constitutional rights.

For these reasons and others discussed below, *amici curiae*, leading medical societies whose policies represent the considered judgments of many physicians in this country, urge the Court to grant the petition so that the Court may consider the compelling question whether the undue burden test articulated in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), entitles a court to preliminarily enjoin the Act without making a concrete estimate of the number of women who would be prevented or postponed in having an abortion.

## ARGUMENT

The Court's review of the decision below is critical to ensuring that Arkansas women are not deprived of access to abortion care. Patient safety is of paramount importance to *amici curiae*, but the Act's contracted physician requirement does nothing to protect the health and safety of women and is inimical to modern medical practice. Laws enacted under the pretense of ensuring patient safety, but that actually harm women's health, should not limit women's access to high-quality, evidence-based abortion care.

The contracted physician requirement imposes constraints on access to safe and legal abortion without any offsetting medical benefit and thereby jeopardizes public health in Arkansas. Without access to abortion, women of reproductive age face significantly increased health risks, including major complications from childbirth and even death. When unnecessary restrictions are placed on abortion care, women's health—and thus public health—suffers.

## I. ACCESS TO REPRODUCTIVE HEALTH SERVICES, INCLUDING ABORTION, IS CRITICAL TO A FULLY FUNCTIONING PUBLIC HEALTH SYSTEM

The contracted physician requirement jeopardizes public health in Arkansas by imposing, without medical basis, legislative constraints on safe and legal abortion. Without access to abortion, women of reproductive age face significantly increased risks to their health.

Abortion is an essential component of comprehensive reproductive care. Over 67 million women of reproductive age reside in the United States, including over six hundred thousand in the state of Arkansas.[2] Meaningful access to affordable reproductive care, including abortion, prevents disease, promotes health, and prolongs life in the whole population. Legal abortion is an important component of repro-

[2] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2014 Update*, Tables 1–2 (2016), https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

ductive care and helps avoid the adverse health consequences that may arise if women are forced to seek care from unauthorized providers—as in the pre-*Roe* era—or the proven health risks of carrying an unwanted pregnancy to term.[3] Depriving women of that care by imposing medically-unnecessary requirements on providers creates an "undue burden" on the exercise of a substantive due process right and creates a severe, immediate, and concrete risk to public health.[4]

*Amici curiae* are not alone in recognizing that meaningful access to abortion is essential to public health. The Association of Reproductive Health Professionals agrees that "[a]bortion care is a critical component of comprehensive reproductive health care" and thus "supports a woman's right to choose to have an abortion," recognizing that "[d]isparities in access to health care are a major public health failure. . . ."[5] The World Health Organization's Department of Reproductive Health and Research states that its "vision" is "the attainment by all peoples of the highest possible level of sexual and reproductive health," which requires eliminating unsafe

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[3] See Part II.C.2, *infra*, at 25–26.

[4] See Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 Hastings L.J. 385, 404 (2013).

[5] Ass'n Reprod. Health Profs., *Position Statements—Access to Reproductive Health Care*, (June 2012), http://www.arhp.org/about-us/position-statements.

abortion.[6] Like *amici curiae*, these organizations recognize safe, legal abortion as a critical component of reproductive health in particular and of public health generally.

## II. THE CONTRACTED PHYSICIAN REQUIREMENT DOES NOT SERVE THE HEALTH OF WOMEN

The Act's contracted physician requirement secures no medical benefit for Arkansas women and is contrary to current medical practice. The Arkansas legislature's claimed purpose for the requirement is to protect women's health. But legal abortion, including medication abortion, is extremely safe, and the contracted physician requirement will not make it safer. Instead, the requirement will only make reproductive care harder to access without improving care for those able to access it.

### A. Legal abortion is an extremely safe procedure.

Legal abortion is extremely safe. It is "one of the most common and safest gynecologic interventions in the United States"[7] and "[m]ajor complications that

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[6] World Health Org., Dep't Reprod. Health & Research, *Our Vision*, http://www.who.int/reproductivehealth/about_us/en/ (last visited Jan. 10, 2018).

[7] APHA, *Policy Statement No. 20112—Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

require hospitalization are rare."[8] Less than one-quarter of one percent of the patient population experiences serious complications arising from legal abortion requiring hospitalization or surgical care.[9]

Deaths from legal abortion are even rarer. In the United States between 1998 and 2010, less than one death occurred per 100,000 legal abortion procedures.[10] By comparison, over the same time period, the Centers for Disease Control and Prevention ("CDC") reported between 12.0 and 17.8 pregnancy-related deaths per 100,000 live births.[11] In short, legal abortion is an exceptionally safe medical procedure and, as discussed below, will not be made safer by the contracted physician requirement.

### B. The contracted physician requirement offers no medical benefit to women.

The contracted physician requirement is not grounded in any evidence-based practice and provides no public health benefit.

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[8] ACOG, *FAQ043 Special Procedures—Induced Abortion* 2 (May 2015), https://www.acog.org/-/media/For-Patients/faq043.pdf?dmc=1&ts=20161103T1611342742.

[9] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

[10] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 258 (2015).

[11] *Pregnancy Mortality Surveillance System*, CDC, http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (last updated Nov. 9, 2017).

More than 90% of U.S. abortion procedures are performed through outpatient clinics.[12] Petitioners provide medication abortions on an outpatient basis and are able to address most complications on an outpatient basis by having the patient contact or return to the clinic.[13] In the small number of cases where it is necessary, patients are referred to a local hospital or to a clinic where they may obtain a surgical abortion.[14] In each case, Petitioners are able to communicate necessary health information to the treating physician without difficulty.

Transferring care from an outpatient provider to an emergency room physician or surgical abortion provider (when necessary) is consistent with standard medical practice.[15] Not only is it accepted, it is expected that anyone suffering complications from a medical procedure will go to their nearest hospital for treatment.[16] Local hospitals are competent to

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[12] Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 46 (Table 4) (2011).

[13] Pet. App. 26a–29a.

[14] *Id.*

[15] See *The Woman's Health Protection Act: Hearing on S. 1696 Before the Senate Comm. on the Judiciary*, 113th Cong. 3 (2014) (testimony of Hal C. Lawrence, Executive Vice President and CEO, ACOG) at 5, https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/20140715S1696Testimony.pdf [hereinafter *Lawrence Testimony*].

[16] APHA, *Policy Statement No. 20151—Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers* (Nov. 3, 2015), *(continued)*

treat complications from medication abortions, which are similar to complications from miscarriages.[17] Seeking care from a local hospital is consistent with modern medical practice and poses no harm to patients; they receive appropriate treatment and cannot be turned away or denied care.[18] For women with continuing pregnancies following medication abortion, a repeat dose of medication or referral for surgical abortion on a non-urgent basis, *i.e.*, Petitioners' protocol, is consistent with ACOG's recommendations.[19] Neither of these options requires a physician with hospital admitting privileges. Moreover, the contracted physician requirement ignores

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https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/14/11/04/opposition-to-requirements-for-hospital-admitting-privileges-for-abortion-providers.

[17] See Updahyay et al., *supra* note 8, at 175–76; see also Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 166 (2013); *Lawrence Testimony*, *supra* note 15, at 15; Letter from Ralph Hale, Exec. V.P. ACOG, to Jane Henney, Comm'r, U.S. Food & Drug Admin. (Jul. 24, 2000), http://www.aaplog.org/wp-content/uploads/2002/05/ACOG AnalysisMifepristone7-27-00.pdf (enclosing ACOG, *Analysis of the Possible FDA Mifepristone Restrictions* 5 (July 27, 2000)).

[18] APHA, *Policy Statement No. 20151*, *supra* note 16.

[19] See ACOG, Comm. on Practice Bulls.—Gynecology & the Soc'y of Fam. Plan., *Practice Bulletin No. 143—Medical Management of First Trimester Abortion*, 123 Obstetrics & Gynecology 676, 677, 680–81 (2014); see also Pet. App. 26a–28a. Continuing pregnancies generally do not require urgent surgical completion. Pet. App. 28a.

that, by the time any complications arise, the very few patients requiring medical attention after an abortion may be hundreds of miles away from the facility at which they obtained abortion services, and likely the contracted physician's hospital.[20] In contemporary practice, continuity of care is achieved by collaboration among specialized health care providers, wherever they are, not by a single doctor following a patient with whom she has no pre-existing medical relationship to a possibly far flung hospital.[21]

Requiring a woman's abortion provider to contract with a third-party physician with hospital privileges does not guarantee that the contracted physician will be available if complications arise; have any familiarity with the patient's history; or improve the care the patient is likely to receive from the hospital specialists who will care for her.[22] At bottom, there is simply no evidence that the con-

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[20] APHA Policy Statement No. 20151, supra note 16.

[21] See *Lawrence Testimony*, *supra* note 15, at 5; see also ACOG, *Opinion No. 657—The Obstetric and Gynecologic Hospitalist* (Feb. 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co657.pdf?dmc=1&ts=20161107T-1513487159; Inst. of Med., *Crossing the Quality Chasm: A New Health System for the 21st Century* 8–9 (Mar. 2001).

[22] See *Lawrence Testimony*, *supra* note 15, at 5 (explaining that a woman experiencing complications will see emergency room physicians, or on-call specialists, and hospitals "increasingly rely on 'hospitalists' that provide care only in a hospital setting").

tracted physician requirement improves women's health or safety.[23]

### C. The Act jeopardizes public health in Arkansas by eliminating medication abortion and limiting abortion care in the state to a single facility in Little Rock.

The contracted physician requirement will eliminate medication abortion in Arkansas and force two of the three clinics in Arkansas that provide abortion services to stop providing these services.[24] Only one abortion provider, which is based in Little Rock, will continue providing legal abortions in Arkansas, and will only be able to provide surgical abortions.[25]

By forcing these facilities to stop providing abortion services and eliminating medication abortion, the Act will deny Arkansas women access to a safe and, for some patients, medically-indicated procedure and force women to travel farther distances to access surgical abortion care. The contracted physician requirement will have a particularly devastating impact on the health and safety of low-income women, who already face considerable barriers to reproductive health care.

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[23] ACOG, *Committee Opinion No. 613—Increasing Access to Abortion* 1062 (Nov. 2014), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion.

[24] Pet. App. 26a–29a.

[25] *Id.*

### 1. The Act will eliminate medication abortion, which is safe and medically-indicated for some patients.

The Act will eliminate medication abortion, which is "an important alternative" to surgical abortion.[26] In 2014, the most recent year for which the CDC has published relevant data, medication abortion accounted for over 22% of reported abortions in the United States.[27] In the same year, nearly half of all abortions performed up to nine-weeks gestation were medication procedures.[28]

The safety of medication abortion is well documented. The medication regimen used by Petitioners, which employs mifepristone, has been approved by the U.S. Food and Drug Administration,[29] has

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[26] Thoai D. Ngo et al., *Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: A Systematic Review*, 89 Bull. World Health Org. 360, 360 (2011).

[27] Tara C. Jatlaoui et al., CDC, *Abortion Surveillance – United States, 2014*, Morbidity & Mortality Wkly. Rep., at 31 (Table 11) (Nov. 24, 2017). Medication abortion accounted for 14 percent of the reported abortions in Arkansas during 2014. *Id.*

[28] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Persp. on Sexual & Reprod. Health 17, 21–22 (2017) (estimating that "45% of abortions up to nine weeks' gestation in 2014 were early medication procedures").

[29] *Mifeprex (Mifepristone) Information*, U.S. Food & Drug Admin., http://www.fda.gov/Drugs/DrugSafety/Postmarket DrugSafetyInformationforPatientsandProviders/ucm111323.htm (last updated Mar. 30, 2016).

been used by Planned Parenthood since 2006, and has improved the safety of medication abortion procedures.[30] Like all medications, mifepristone carries some risks. But it is as safe, or safer, than many other drugs used today, including Tylenol and Viagra.[31]

In many circumstances, medication abortion is preferable to surgical abortion. For example, in the first seven weeks of pregnancy, medication abortion "is usually more effective than early aspiration," the surgical method used for early abortion procedures.[32] Many women also prefer medication abortion to surgery, and believe that medication abortion is more natural than a surgical abortion.[33] In one study, 71% of participants reported that they strongly preferred medication abortion to surgical abortion.[34]

Medication abortions are safer than surgical abortions for some women, including those who are extremely obese, have large uterine fibroids, or have

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[30] James Trussell et al., *Reduction in Infection-Related Mortality since Modifications in the Regimen of Medical Abortion*, 89 Contraception 193, 193 (2014) (finding that Planned Parenthood's evidence-based medication abortion protocol reduced mortality rates in medication abortions); *ACOG Practice Bulletin No. 143*, *supra* note 19, at 677.

[31] *Lawrence Testimony*, *supra* note 15, at 3.

[32] Marge Berer, *Medical Abortion: Issues of Choice and Acceptability*, 13 Reprod. Health Matters 25, 27 (2007).

[33] *Id.* at 26–27.

[34] Daniel Grossman, et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine,* 118 Obstetrics & Gynecology 296, 301 (2011).

a narrow cervix.[35] For women who are sexual assault survivors, medication abortion minimizes the need for invasive exams, consistent with recommended medical practice in treating such patients.[36]

"[C]omplications with [medication] abortion are relatively infrequent."[37] Less than one percent of medication abortions performed at Planned Parenthood clinics in 2009 and 2010 resulted in significant adverse events or outcomes.[38] Only 0.10% of cases resulted in emergency department treatment, 0.06% resulted in hospital admission, and 0.05% resulted in a blood transfusion.[39] In fact, continuing pregnancy, which "is not a complication that is related to the safety of [medication] abortion the same way serious infection or blood transfusion is," was

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[35] *Lawrence Testimony*, *supra* note 15, at 3.

[36] World Health Org., *Guidelines for Medico-Legal Care for Victims of Sexual Violence* 17 (2003), http://apps.who.int/iris/bitstream/10665/42788/1/924154628X.pdf.

[37] Cleland et al., *supra* note 17, at 166; see also Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 Obstetrics & Gynecology 22, 22 (2015).

[38] Cleland et al., *supra* note 17, at 166 (defining "significant adverse events" as "hospital admission, blood transfusion, emergency department treatment, intravenous antibiotics administration, infection, and death" and "significant outcomes" as "ongoing pregnancy and ectopic pregnancy diagnosed after [medication] abortion treatment was initiated").

[39] *Id.* at 169 (Table 2).

the most commonly reported significant adverse effect or outcome.[40]

By eliminating medication abortion in the state, the Act will deny Arkansas women access to a common, safe, highly-effective, and, in some cases, medically-indicated abortion procedure. The Act will leave Arkansas women with one choice: surgical abortion at the single remaining clinic in Little Rock.

### 2. Arkansas is particularly vulnerable to public health risks, including restrictions on reproductive care.

The risks to public health caused by restricted access to medication abortion services are particularly acute in Arkansas. Arkansas has one of the highest poverty rates in the United States; over seventeen percent of Arkansans live below the poverty line.[41] Arkansas's population is not only poor, but also largely rural,[42] making access to abortion

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[40] *Id.* at 169 ("Continuing pregnancy is of clinical significance only if it is unrecognized through follow-up and the patient does not have a surgical abortion.").

[41] See Talk Poverty, *Overall Poverty, 2017*, https://talkpoverty.org/indicator/listing/poverty/2017 (last visited Jan. 10, 2018). Only five states—Mississippi, New Mexico, Louisiana, Kentucky, and West Virginia—have higher poverty rates. *Id.*

[42] See Iowa Community Indicators Program, *Urban Percentage of the Population for States, Historical*, Iowa State Univ., http://www.icip.iastate.edu/tables/population/urban-pct-states (last visited Jan. 10, 2018) (showing that only 56.2% of Arkansans lived in an urban area, among the lowest proportion in the nation, according to 2010 U.S. Census Bureau data).

care especially challenging.[43] In addition, Arkansas has one of the highest rates of sexual violence in the country, making medication abortion an important option in the state because it permits providers to "minimize the number of invasive physical examinations" of sexual assault survivors.[44] Arkansas women are particularly vulnerable to the ratcheting up of abortion restrictions because the state already severely burdens abortion care through existing regulations while providing inadequate support for family planning and maternal health.

Low-income women in Arkansas face significant financial barriers to accessing reproductive care, which will be exacerbated if the contracted physician requirement is permitted to take effect. The majority of women seeking abortion care already have at least one child.[45] The federal poverty line for a single per-

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[43] ACOG, *Committee Opinion No. 613*, *supra* note 23, at 1063; see also ACOG, Comm. on Health Care for Underserved Women, *Opinion No. 586—Health Disparities in Rural Women*, 123 Obstetrics & Gynecology 384, 385 (2014) (stating that "[l]ocal availability of abortion services . . . is a concern" for rural women).

[44] *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, *supra* note 36, at 17; Fed. Bureau Investigation, *Crime in the United States by State, 2016* (Table 3), https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/tables/table-3 (indicating that Arkansas had the fifth-highest rate of rape in the country in 2016).

[45] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358, 1363 (2011).

son with a child in 2017 was $16,240, which equates to a monthly income of $1,353.[46] The current fair market rent for a one-bedroom apartment in or near Fayetteville, Arkansas is $578 per month.[47] The numbers suggest that a single woman with one child living at the poverty line and paying fair market rent for a one-bedroom apartment in Fayetteville would have a mere $775 of monthly income after rent to cover transportation, clothing, food, and other necessities for herself and her child. In Arkansas, over 40% of single-parent families live below the poverty line and earn even lower incomes.[48] An abortion costs hundreds of dollars[49] and with only rare exceptions, neither federal nor state Medicaid will cover the cost of abortion care for women in Arkansas.[50]

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[46] See *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*, U.S. Dep't of Health & Human Servs. (Jan. 26, 2017), https://aspe.hhs.gov/2017-poverty-guidelines.

[47] Fair Market Rent Documentation System, FY 2017 Fayetteville-Springdale-Rogers, AR HUD Metro FMR Area FMRs for All Bedroom Sizes, U.S. Dep't of Hous. & Urban Dev., https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2017_code/2017summary.odn (last visited Jan. 10, 2018).

[48] *Arkansas*, Spotlight on Poverty & Opportunity, http://spotlightonpoverty.org/states/arkansas/ (last visited Jan. 10, 2018).

[49] Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1772, 1776 (2013).

[50] See Stanley K. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature*

*(continued)*

Further, due to a combination of factors, including lack of access to medical services and difficulty accessing and affording contraceptives,[51] low-income women have more unintended pregnancies and higher abortion rates than women with higher incomes.[52] In 2014, approximately 49% of American women who had abortions had incomes below the federal poverty level, and an additional 26% of women who had abortions qualified as low-income.[53] The combination of low incomes, unintended pregnancies, and higher abortion rates is felt more acutely by Arkansas women, who are not only, on average,

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*Review* 3 (2009), https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review (explaining that Medicaid funding of abortion is available to Arkansas women only in cases of rape, incest, or life-endangering physical condition).

[51] *See, e.g.*, Dehlendorf et al., *supra* note 49, at 1772; Guttmacher Inst., *Contraceptive Use in the United States* 1 (2016), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states; Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. Health Care for Poor & Underserved 415, 415 (2011).

[52] "The rate of unintended pregnancy among poor women . . . was 112 per 1,000 aged 15-44 in 2011, more than five times the rate among women at the highest income level (20 per 1,000)." Guttmacher Inst., *Unintended Pregnancy in the United States* 2 (2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. The rate of abortion was also significantly higher among low-income women. See Dehlendorf et al., *supra* note 49, at 1772.

[53] Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 1 (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.

poorer than women nationally, but also more likely to have unintended pregnancies.[54]

By restricting access to abortion through other legislation, Arkansas has already damaged the health of the individual women and children who live in the state. Even before the Act was passed, Arkansas placed 49th in the country in terms of women's health, far behind states like Vermont or Massachusetts, which place relatively few obstacles to abortion access.[55] Arkansas requires women seeking an abortion to participate in state-directed counseling that includes information designed to discourage abortion and to wait at least 48 hours after that counseling before proceeding with an abortion.[56]

The public health impact of Arkansas's legislative obstacles to abortion access is compounded by the state's lack of support for family planning services or birth control. Publicly-supported family planning centers in the state meet only 29% of Arkansas

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[54] In 2010, 55% of pregnancies in Arkansas were unintended, as compared to 45% of pregnancies nationwide. Guttmacher Inst., *State Facts About Unintended Pregnancy: Arkansas* 1 (2016), https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-arkansas.

[55] Nat'l Women's L. Ctr., Making the Grade on Women's Health: A National State by State Report Card, Key Findings, http://hrc.nwlc.org/key-findings (last visited Jan. 10, 2018).

[56] See Ark. Code Ann. § 20-16-1703 (2015).

women's need for contraceptive care.[57] In 2010, 55% of all pregnancies in Arkansas were unintended.[58] That same year, 67% of unintended pregnancies in the state resulted in births and 18% in abortions.[59] By underfunding publicly supported family planning services, the Arkansas legislature has increased the likelihood of unintended pregnancy, leading to greater need for comprehensive reproductive care, including abortion.

If the contracted physician requirement goes into effect, thousands of Arkansas women will need to travel hundreds of miles to the state's single remaining facility multiple times to comply with the state's mandatory waiting period. This poses a heavy burden. Women will need to pay for the costs of travel—including transportation, overnight lodging, and child care[60]—on top of the cost of the abortion itself. If a woman is able to obtain an abortion, but must delay the procedure due to the increased obstacles put in her path by the contracted physician requirement, she faces increased risks.[61] Some women may be prevented from obtaining an abortion at all, be

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[57] Guttmacher Inst., *State Facts About Unintended Pregnancy: Arkansas*, *supra* note 54, at 2.

[58] *Id.*

[59] *Id.*

[60] 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).

[61] Linda Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).

forced to carry an unwanted pregnancy to term, which poses a greater risk than having an abortion, and experience the physical and mental burdens of pregnancy and childbirth.

The Act's overall detrimental impact on public health exacerbates medical inequality.[62] The effects of the contracted physician provision will likely be particularly acute for low-income women in western Arkansas, which is home to two of Arkansas's largest cities, Fayetteville and Fort Smith.[63] The U.S. Census Bureau reported that over a quarter of Fayetteville and Fort Smith residents (25.2% and 25.9% respectively) live below the federal poverty line.[64] For such patients, the out-of-pocket cost of the abortion procedure alone is substantial, and the additional costs, challenges, and requirements that the Act imposes may be prohibitive. Even researching and planning for an abortion procedure can be a challenge for those who lack internet access and Arkansas is ranked second-to-last in the United States in terms of Internet connectivity.[65]

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[62] Dehlendorf et al., *supra* note 49, at 1775–77.

[63] *Arkansas - Largest Cities,* GeoNames, http://www.geonames.org/US/AR/largest-cities-in-arkansas.html (last visited Jan. 10, 2018).

[64] *American Fact Finder*, U.S. Census Bureau, http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml (last visited Jan. 10, 2018) (search Fayetteville and Fort Smith before navigating to the "Poverty" tab on each webpage).

[65] Camille Ryan & Jamie M. Lewis, *Computer and Internet Use in the United States: 2015*, United States Census

*(continued)*

Currently, Fayetteville is the only Arkansas city other than Little Rock to offer abortion care. If the contracted physician requirement is permitted to take effect, the Fayetteville facility will no longer be able to provide abortion services. Women in Fayetteville would have to make the 380-mile round-trip to Little Rock to see an abortion provider, and will no longer be able to obtain a medication abortion at all.[66] Likely, Fayetteville women would need to make the round trip to Little Rock twice, once for the required state-directed counseling, and once again, 48 hours later, for the procedure.[67] For those women who have access to an automobile, the fuel alone for the 760 mile trip costs roughly $64.[68] And in Fayetteville, access to a car cannot be assumed. As of 2006, over 10,000 Fayetteville residents lived in households without access to an automobile.[69]

The bus route from Fayetteville to Little Rock is long, slow, expensive, and infrequent. It runs once daily in both directions, departing from Fayetteville

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Bureau (Table 2) https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf.

[66] Pet. App. 88a.

[67] See Ark. Code Ann. § 20-16-1703 (2015). This does not include the additional follow-up visit which the Act requires to be scheduled. See Pet. App. 122a.

[68] Assuming a vehicle with 25 mpg, and a fuel price of $2.11 per gallon.

[69] Alan Berube et al., Univ. of Cal. Transp. Ctr., *Socio-economic Differences in Household Automobile Ownership Rates: Implications for Evacuation Policy* (June 2006), https://escholarship.org/uc/item/7bp4n2f6.

at 1:55 a.m. and from Little Rock at 5:45 a.m. It takes roughly four to five hours, and costs roughly $75 to $122 round-trip.[70] Thus, a Fayetteville woman seeking abortion care must take the bus from Fayetteville to Little Rock at 1:55 a.m. on day one, arrive in Little Rock in the early morning, walk or take a cab ten miles to the clinic, undergo state-mandated counseling, find somewhere to sleep in Little Rock, and then leave at 5:45 a.m. on day two to return to Fayetteville. She would then have to repeat this journey after the 48-hour waiting period had elapsed. Travel from other, rural areas, will pose similar, if not more onerous, challenges.[71]

By limiting abortion care to just a single clinic in the entire state, Arkansas's contracted physician requirement would force women across the state to surmount formidable challenges in order to get basic, safe, reproductive care. For poor and working class women, the costs and time required to travel hundreds of miles multiple times to the last remaining facility may well be prohibitive.

Studies show that when access to abortion care is limited, women are more likely to carry an unwanted pregnancy to term, which poses greater risk to the

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[70] Greyhound, https://www.greyhound.com/ (last visited Jan. 10, 2018) (search for roundtrip fares between Fayetteville and Little Rock).

[71] The bus route from Fort Smith to Little Rock is similar. See Greyhound, https://www.greyhound.com/ (last visited Jan. 10, 2018) (search for roundtrip fares between Fort Smith and Little Rock).

woman's health than legal abortion.[72] All pregnancies carry physical and psychological risks.[73] The risk of death associated with childbirth is roughly ten times that associated with abortion.[74] Women who undergo unintended childbirth are also at increased risk for maternal depression,[75] and unwanted births carry increased risks of congenital anomalies, premature delivery, and low birth weight.[76] If Arkansas women are forced to travel farther to obtain an abortion, they are less likely to obtain one and thus are more likely to suffer from complications associated with bringing a pregnancy to term.[77] This is especially true for women of color.[78]

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[72] Paul M. Fine Decl., at 20–21, ¶ 55, *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB (E.D. Ark.), ECF No. 2.

[73] See generally World Health Org., *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (2000), http://apps.who.int/iris/bitstream/10665/43972/1/9241545879_eng.pdf.; *Pregnancy Complications*, CDC, http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm (last updated June 17, 2016).

[74] Guttmacher Inst., *State Facts About Abortion: Arkansas* 1 (2015), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-arkansas.

[75] Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18, 28 (2008).

[76] *Id.* at 24.

[77] See James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260, 260 (1976).

Furthermore, Arkansas's high rate of maternal mortality,[79] which is 32% above the national average,[80] suggests that its residents are particularly vulnerable to the risks associated with unwanted pregnancy.

Limiting access to legal abortion providers does not substantially lower pregnancy rates, nor does it eliminate the need for abortion services.[81] Rather, it simply makes it less likely that women will be able to obtain safe and legal abortion care.[82] And when

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[78] See Robert W. Brown et al., *Provider Availability, Race, and Abortion Demand*, 67 S. Econ. J. 656, 667 (2001) (finding that increasing the distance to the closest abortion provider by 10% would reduce the probability of abortion by 5.01% and 2.70% for Hispanics and African Americans). Racial minorities account for approximately half of the abortions reported in Arkansas. See *Induced Abortions Data – Act 353, 2015*, Ark. Dep't of Health, http://cdm16039.contentdm.oclc.org/cdm/ref/collection/p266101coll7/id/22784 (last visited Jan. 10, 2018).

[79] Nat'l Women's L. Ctr., *Making the Grade on Women's Health: A National State by State Report Card, Maternal Mortality Rate (per 100,000)* (2010), http://hrc.nwlc.org/status-indicators/maternal-mortality-rate-100000 (last visited Jan. 10, 2018).

[80] *Id.*

[81] Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 Lancet 625, 625 (2012); Guttmacher Inst., *Induced Abortion Worldwide* 1 (2016), https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide.

[82] See Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt. 775, 777 (2011); see also Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54, 54 (1995).

access to abortion is compromised, some women will attempt to obtain abortions from unauthorized providers or through self-treatment.[83] These abortions, unlike abortions performed by skilled providers, may pose higher risks of health complications and death.[84] Indeed, illegal abortion was a major cause of death and injury for pregnant women in the pre-*Roe* era.[85] If the contracted physician provision is permitted to become effective, illegal abortion rates in Arkansas could rise, as will the attendant increased risks of death and injury.

* * *

The Act does nothing to further the safety of abortions or the competency of those performing them in Arkansas. Indeed, legal abortions performed in Arkansas prior to the Act met or exceeded safety expectations for outpatient medical procedures. The Act is an unnecessary regulation that presents risks to women's health by restricting and delaying access to safe abortion. Accordingly, *amici curiae* urge the Court to grant the petition for a writ of certiorari in order to review whether the Act can withstand constitutional scrutiny.

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[83] See Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reprod. Health Matters 136, 136 (2010).

[84] Gilda Sedgh et al., *supra* note 81, at 625–26.

[85] Rachel Benson Gold, *Lessons from Before* Roe*: Will Past Be Prologue?*, Guttmacher Rep. on Pub. Pol'y, at 8 (Mar. 2003) (noting that the death toll was one "stark indication" that illegal abortions were common).

## CONCLUSION

For the foregoing reasons, *amici curiae* urge the court to grant the petition for a writ of certiorari.

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February 1, 2018.