No. 19-1392

IN THE

Supreme Court of the United States

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, *et al.*,

Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICUS CURIAE* COMMISSIONER ANDY GIPSON, FORMER REPRESENTATIVE AND CHAIR OF MISSISSIPPI HOUSE JUDICIARY B COMMITTEE, IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether all pre-viability prohibitions on elective abortions are unconstitutional.

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INTEREST OF *AMICUS CURIAE*

Amicus[1] is one of the primary sponsors of H.B. 1510 in the Mississippi House of Representatives. Former Representative Andy Gipson, who currently serves as Mississippi's Commissioner of Agriculture and Commerce, co-sponsored the bill and chaired the House of Representatives Judiciary B Committee that recommended the bill. Amicus has an interest in promoting life and protecting women who seek abortions. Additionally, amicus has a specific interest in informing this Court why he sponsored H.B. 1510: to protect unborn life, women's health, and the medical profession's integrity. He also wants to explain how H.B. 1510 works in conjunction with Mississippi's plethora of programs and services that provide care for women during and after pregnancy and support them in caring for children after birth.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

The Gestational Age Act is part of Mississippi's robust framework of legislation, state programs, and public-private partnerships designed to promote and support life. During the first trimester, women in Mississippi have access to comprehensive family planning resources and pre-natal healthcare through county health departments, as well as community health centers, crisis pregnancy homes, and licensed adoption agencies. This includes

1. Pursuant to Supreme Court Rule 37(6), amicus states that no one other than amicus and his counsel authored this brief in whole or part or contributed money intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief in blanket consents on file.

access to information and counseling regarding options for terminating or continuing their pregnancies. The Act simply requires that women who seek nontherapeutic abortions do so in the first trimester, before 15 weeks' gestational age. Thereafter, the Act allows abortions only in cases of medical emergencies or severe fetal abnormalities.

For women who choose to continue their pregnancies, Mississippi offers a number of resources to support them through birth and throughout the child-rearing years. These resources include additional family planning services, pre-natal healthcare, and connections to public and private services that assist women with infants. In addition, Mississippi actively supports families who need help to provide their children with proper nutrition, healthcare, daycare, and education. The State fosters partnerships with private organizations that serve disadvantaged families in local communities, and it facilitates foster care and adoption programs with an innovative tax credit system to respond to circumstances in which the birth parents are not able to raise the child. In short, Mississippi strives to assist any woman who needs resources to care for a child, whether born or unborn.

The Act was struck down solely on the basis of the district court's finding that it constituted a pre-viability restriction on abortion, which the Fifth Circuit affirmed because of this Court's precedents regarding pre-viability restrictions on abortions. The lower courts gave no consideration to Mississippi's legitimate interests or the evidence the State proffered to substantiate those interests, nor did the district court make any factual findings that the Act poses an undue burden to any woman seeking an abortion. This was error.

The Act is supported by at least three compelling state interests. First, it furthers Mississippi's interest in promoting life by protecting unborn children from nontherapeutic abortions after the first trimester. The Act draws a line at 15 weeks' gestational age because, by that point, the child has taken on "the human form" in all relevant aspects. *Gonzales v. Carhart*, 550 U.S. 124, 160 (2007). The Legislature rightly concluded that, by the end of the first trimester, there is a compelling state interest in protecting the developing child and preventing fetal pain regardless of the child's viability.

Second, the Act furthers Mississippi's interest in protecting women from the health risks of unnecessary abortions. The Act is supported by findings that the physical and psychological risks of abortion increase substantially as gestational age increases, becoming greater than the risks of carrying a pregnancy to term as the second trimester progresses. The Act prevents women from unnecessarily assuming these increased risks. In situations where exigent circumstances arise in the second and third trimester, the Act contains a health exception for women who need it.

Third, the Act is supported by Mississippi's interest in protecting the integrity of the medical profession. Abortions after the 15-week mark set by the Act are performed using the dilation and evacuation procedure, which involves "the use of surgical instruments to crush and tear the unborn child apart before removing the pieces of the dead child from the womb." Miss. Code Ann. § 41-41-191(2)(b)(i)(8) (2018); *see also Gonzales*, 550 U.S. at 135 (stating that D&E "causes the fetus to tear apart"). The Act simply recognizes the fact that D&E is inhumane

and "that the intentional commitment of such acts for nontherapeutic or elective reasons is a barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession." Miss. Code Ann. § 41-41-191(2)(b)(i)(8) (2018).

Finally, the Act does not impose an undue burden on women seeking abortions in Mississippi. Assuming arguendo that this standard applies,[2] there is no evidence that a 15-week decision-making period is a substantial obstacle to a woman seeking a nontherapeutic abortion in Mississippi, nor is there any reason to conclude that a woman cannot make a decision regarding the termination of her pregnancy within the first trimester. The district court's rote application of the flawed viability standard had no factual basis and improperly disregarded the State's interests in protecting unborn life, women's health, and the medical profession's integrity.

ARGUMENT

I. The Mississippi Legislature values life before and after birth.

It is well settled law that a state legislature has the ability and responsibility to enact laws to protect its citizens.[3] This responsibility extends to promulgating laws

2. Petitioners' brief correctly and persuasively argues that the Act should be subject to rational-basis review, which it satisfies.

3. U.S. Const. amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."); *see, e.g.*, *State v. J.J. Newman Lumber Co.*, 102 Miss. 802, 925-

on behalf of the people it represents to support their health and well-being and protect them from medical injury or unnecessary pain and suffering. A state legislature's interest in protecting its citizens in this manner extends all the more when a woman is carrying an unborn child: there, the health and well-being of two lives are at stake.[4]

The State of Mississippi takes seriously its responsibility to consider the interests of its people in enacting legislation on their behalf, as Mississippi's elected leaders did in 2018 by passing the Gestational Age Act (the "Act"). Miss. Code Ann. § 41-41-191 (2018). The Act itself contains the Legislature's findings that informed this measure to protect women, unborn children, and the medical profession, including: a) the milestones of human prenatal development, culminating in the statement that by twelve weeks, the unborn child "has taken on the human form in all relevant aspects"; b) that after 15 weeks, the majority of abortions are performed by a dilation and evacuation procedure, which the Legislature found to be "a barbaric practice, dangerous for the maternal

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926 (Miss. 1912) ("Section 33, art. 4, of Mississippi's Constitution, clearly announces that 'the legislative power of this state shall be vested in the Legislature.' . . . It is the duty of the Legislature to consider the interests of all—what is best for society generally. . . [t]hey are necessarily the judges of what is for the good of the citizens. . . . [T]he power of the state to enact laws for the government of its people . . . extends at least to the lives, the health, the general welfare and safety of the public . . . .").

4. *See Gonzales*, 550 U.S. at 157 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) ("[T]he State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.")).

patient, and demeaning to the medical profession"; and c) that "significant physical and psychological risks to the maternal patient" increase with gestational age, such that "as the second trimester progresses, in the vast majority of uncomplicated pregnancies, the maternal health risks of undergoing an abortion are greater than the risks of carrying a pregnancy to term." Miss. Code Ann. § 41-41-191(2)(b) (2018). The Legislature explicitly noted its authority to take such action to restrict abortions past 15-week gestational age in line with the precedent of this Court, which has "long recognized that the State of Mississippi has an 'important and legitimate interest in protecting the potentiality of human life,' *Roe v. Wade*, 410 U.S. 113, 162 (1973), and specifically that 'the state has an interest in protecting the life of the unborn.' *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 873 (1992)." Miss. Code Ann. § 41-41-191(2)(b)(7) (2018). The Legislature permitted abortions to occur after the 15-week mark in cases of medical emergencies or severe fetal abnormalities. *Id.* § 41-41-191(4).

The Legislature's concern for the health and welfare of women is not limited to enacting measures related to abortion. Far from the accusations often directed at legislatures that laws enhancing abortion restrictions negatively impact women, including by the district court in the case below,[5] the Mississippi Legislature has enacted numerous laws to ensure significant resources are available to women through all stages of family planning and to support families in caring for children after birth.

5. *See Jackson Women's Health Org. v. Currier*, 349 F. Supp. 3d 536, 540 n.22, 543 (S.D. Miss. 2018), *aff'd sub nom. Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019).

The Legislature has enacted legislation specifically aimed at the needs of women, including medical needs, outside of pregnancy and childbirth (*see infra* Part I.A), and it has enacted measures aimed to benefit the health and development of young children, starting at birth and continuing through childhood (*see infra* Part I.B). The Act is merely one among numerous laws enacted by the Mississippi Legislature—representing the people it is elected to serve— that demonstrates the value it places on the life and health of both women and children.

A. The State of Mississippi provides assistance for mothers and families from conception onward.

The State of Mississippi provides a robust array of programs and services that provide care for women before, during, and after pregnancy and which support families in caring for children after birth.[6] These services have been initiated over the years through legislative action and continue to be funded through state appropriations, demonstrating the ongoing attention and financial support the Legislature provides for its women and children. For example, the Mississippi State Department of Health has a comprehensive family planning resource structure in place through the State's county health departments.[7]

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6. *See* Mississippi State Department of Health, *Women and Children's Health*, at https://www.msdh.ms.gov/msdhsite/_static/41.html.

7. *See* Mississippi State Department of Health, *Family Planning and Reproductive Health*, at https://www.msdh.ms.gov/msdhsite/_static/41,0,107.html (describing services provided by county health departments, including: physical examinations; family planning counseling and education on contraceptive

These county health departments provide pregnant women with a number of services, including pregnancy tests, counseling, maternity care, and information regarding the options available to them in deciding whether to continue or terminate a pregnancy.[8] The Mississippi State Department of Health also provides women numerous resources for family planning and pre-natal care through community health centers, crisis pregnancy centers, and licensed maternity homes.[9] Many of these services are provided by private organizations working in conjunction with public agencies.[10]

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methods, including abstinence and natural family planning; testing for pregnancy, HIV and sexually-transmitted diseases; birth control supplies; and care coordination for certain high-risk clients.) The State provides free family planning resources and birth control for eligible residents. *See* Mississippi Division of Medicaid, *Family Planning*, at https://medicaid.ms.gov/medicaid-coverage/who-qualifies-for-coverage/family-planning/.

8. Mississippi State Department of Health, *Pregnancy and Perinatal Health*, at https://www.msdh.ms.gov/msdhsite/_static/41,0,376.html; Mississippi State Department of Health, *Informed Consent Information* (Mar. 2018), at https://www.msdh.ms.gov/msdhsite/_static/resources/7582.pdf.

9. *See* Mississippi State Department of Health, *Informed Consent*, https://msdh.ms.gov/msdhsite/_static/41,0,107,272.html; Mississippi State Department of Health, *Informed Consent Resources List*, https://www.msdh.ms.gov/msdhsite/_static/resources/1426.pdf (listing numerous crisis pregnancy centers, maternity counseling centers, maternity homes, and licensed adoption agencies in Mississippi).

10. *See* sources cited *supra* n. 9; *see also* Mississippi State Department of Health, *Women and Children – Family Planning – Resources*, at http://www.healthyms.com/msdhsite/_static/41,0,107,86.html; *Mississippi State Department of Health*

Should a woman decide to carry the child to term and determine that she cannot care for her baby after birth, the State has multiple licensed agencies that place children with adoptived families.[11] A mother may also anonymously release her child to emergency medical personnel, without inquiry, under the State's Baby Drop-Off Law. Miss. Code Ann. § 43-15-201 (2021). This is an important resource for a young mother who may realize after the child's birth that she is not prepared to raise an infant. The Legislature recently amended this law to extend the period during which a new mother may make such a decision to release her child from 72 hours to seven days. Miss. Code Ann. § 43-15-201, 2020 Miss. Laws Ch. 389 (H.B. No. 96) § 1.

In addition, the Legislature has put forth several bills in recent years that demonstrate support and concern for women and infants during and after pregnancy. For example, the Legislature enacted a law in 2009 to address health and developmental issues of infants born prematurely, including providing follow-up health care. Miss. Code Ann. § 43-13-147, 2009 Miss. Laws Ch. 553 (H.B. 1449). The Legislature created an infant mortality reduction collaborative in 2015 (and extended its term in 2017), charged with recommending various regulatory changes to state agencies on preventing preterm deliveries, ensuring access to pre-conception health care, and developing care strategies around the time of birth.[12]

Delegate Agency Locator, at https://www.msdh.ms.gov/msdhsite/_static/resources/13636.pdf.

11. *See* sources cited *supra* n. 9; *see also* Mississippi State Department of Health, *Adoption Services*, at https://www.msdh.ms.gov/msdhsite/_static/resources/7528.pdf.

12. Although this particular collaborative has expired, the Mississippi State Department of Health is charged by the

Miss. Code Ann. § 41-89-21 (repealed by its own terms, eff. July 1, 2020), 2015 Miss. Laws Ch. 492 (H.B. No. 910); 2017 Miss. Laws Ch. 323 (H.B. No. 456), eff. July 1, 2017. Another bill authorized the Department of Health to establish the Maternal Mortality Review Committee to assess maternal deaths and establish strategies to prevent them.[13] Miss. Code Ann. § 41-112-1, 2017 Miss. Laws Ch. 321 (H.B. No. 494) § 1. A 2016 measure supported and promoted breast-feeding by, among other things, informing mothers about the benefits of breast-feeding, and authorizing hospitals with birthing facilities to implement an infant feeding policy that supports breast-feeding and to train all relevant staff to implement the policy. Miss. Code Ann. §§ 41-135-1 through 41-135-9, 2016 Miss. Laws Ch. 502 (S.B. 2070). Hudson's Law requires health care providers to provide educational information to new or expectant parents who receive a positive test regarding their child for a chromosomal disorder. *See* Miss. Legis. S.B. 2746 (2021), 2021 Miss. Laws S.B. 2746. In March 2021, the Mississippi Legislature passed the Dignity for Incarcerated Women Act, which requires compassionate pre-natal and childbirth care for pregnant women who are incarcerated in state facilities. Miss. Legis. H.B. 196 § 4 (2021), 2021 Miss. Laws H.B. 196. And the Legislature recently expanded Medicaid benefits

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Legislature with preparing an annual report on infant mortality. Miss. Code Ann. § 41-3-15(1)(c)(viii) (2020). The latest full report is dated 2019 and is available at https://www.msdh.ms.gov/msdhsite/_static/resources/8431.pdf.

13. The Mississippi State Department of Health has published a Mississippi Maternal Mortality Report 2013-2016, updated in 2019 and addended in March of 2021, which is available at https://www.msdh.ms.gov/msdhsite/_static/resources/8127.pdf.

for mothers and children, including full coverage for maternity care and providing childhood vaccinations free of charge. Miss. Legis. S.B. 2799, 2021 Miss. Laws S.B. 2799 (amending Miss. Code Ann. §§ 43-13-117(A)(6), (59)).

B. The State of Mississippi provides support for children starting at birth.

The State of Mississippi and its legislators are not just concerned about pregnant women and their unborn children. The State also provides numerous resources to women who choose life, and to families who need assistance caring for children after birth by providing resources for healthcare, nutrition, child care, and education.[14] For example, the county health departments provide mothers with access to immunizations for their children, as well as access to the State's Women, Infants and Children Program.[15] The Department of Human Services provides numerous resources to children and their families through two divisions: Early Childhood Care and Development, and Child Support.[16] For example, the Healthy Families Home Visiting program, offered through the Healthy Families Mississippi initiative, provides in-home services and education to women and

14. *See* Mississippi State Department of Health, *Women and Children's Health*, at https://www.msdh.ms.gov/msdhsite/_static/41.html; sources cited *infra* n. 16-17.

15. *See* Mississippi State Department of Health, *Immunizations*, at https://msdh.ms.gov/msdhsite/_static/41,0,71.html; and *WIC Nutrition Program*, at https://msdh.ms.gov/msdhsite/_static/41,0,128.html.

16. *See* Mississippi Department of Human Services website at https://www.mdhs.ms.gov/.

families both during pregnancy and after the baby is born.[17] Here too, the State collaborates with private organizations to provide ample resources to women and families raising children, including healthcare, behavioral therapy and assistance with special needs, child care, food and nutrition, literacy and education, and adoption and foster care services (among others).[18]

In recent years, the Legislature has established licensing standards for prescribed pediatric extended care centers, which provide specialized day care to children with ongoing medical needs. Miss. Code Ann. §§ 41-7-191, 43-13-117 (as amended), 2012 Miss. Laws Ch. 524 (S.B. 2700). It provided eligibility for Medicaid benefits to all children adopted through a state-supported adoption agency, with the possibility of extending benefits through age 21 where the child requires it. Miss. Code Ann. §§ 93-17-61, -67 (as amended), 2008 Miss. Laws Ch. 541 (S.B. 2601). And the Legislature passed the Children's Promise Act, a key example of the State's public and private sectors partnering together to strengthen services to children. Miss. Code Ann. §§ 27-7-22.32, -22.39, 2019 Miss. Laws Ch. 484 (H.B. 1613). Through two separate bills, the Legislature provided innovative tax credits for donations made to nonprofits working with the Department of Child Protection Services to provide foster care and educational services and to help low-income families and children with special needs. The Legislature also recently established

17. *See* Mississippi Department of Human Services, *Healthy Families Mississippi*, at https://www.mdhs.ms.gov/hfm/.

18. *See* Mississippi Department of Human Services, *My Resources*, at https://myresources.mdhs.ms.gov/ (listing public and private family services resources available to Mississippians).

the Mississippi State Foster Care Fund to increase funding to support foster families and children. Miss. Code Ann. § 37-26-11, 2019 Miss. Laws Ch. 412 (S.B. 2196).

Mississippi has also taken the lead as one of few states across the country that provide state funding for preschool education and programs for children with special needs. The Legislature passed the Early Learning Collaborative Act in 2013, which provides funds for early childhood education in underserved areas throughout Mississippi.[19] The Mississippi Legislature has continued to expand enrollment in quality preschools through this program by incremental increases in state appropriations, investing over $40 million since 2013. In addition, the Legislature passed the Equal Opportunity for Students with Special Needs Act in 2015.[20] The program's purpose is to assist parents of special needs children with financial assistance to place their child in a non-public school setting, allowing parents to choose the educational services they believe best meet the needs of their child. Hundreds of special needs students are served each year through this education savings account program.

In summary, the Act is simply one element of a broad scope of laws enacted by the Mississippi Legislature to further the State's interests in improving the health and welfare of women and children. The Legislature acted squarely within its federal and constitutional rights in passing it.

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19. Miss. Code Ann. §§ 37-21-3, -5, -51, -53, -55, 37-07-301, 2013 Miss. Laws Ch. 493 (S.B. 2395).

20. Miss. Code Ann. § 37-181-1, 2015 Miss. Laws Ch. 441 (S.B. 2695).

II. The Mississippi Legislature has an interest in protecting unborn life.

H.B. 1510 contains a number of findings regarding the State's interests, which were disregarded by the district court when it chose to limit its inquiry to "whether the [Act's] 15-week mark is before or after viability." *Jackson Women's Health Org., et al., v. Currier*, 349 F. Supp. 536, 539-40 (S.D Miss. 2018). The district court refused to consider the Mississippi Legislature's interests, including protecting unborn lives from unnecessary abortions, protecting women's health from the increased risks of second and third trimester abortions, and protecting the integrity of the medical profession. The district court's refusal was insulated from appellate review by the abuse-of-discretion standard. *Jackson Women's Health Org., et al., v. Dobbs*, 945 F.3d 265, 274-75 (5th Cir. 2019). The State's interests, however, are compelling.[21]

21. The district court's rationale does not withstand scrutiny. It "invoked relevance to deny evidentiary development concerning fetal pain" and then proceeded to "consider a wide range of [irrelevant] historical matters entirely unconnected to the enactment of HB 1510 in order to impugn the motivations of citizens and policymakers who believe in the sanctity of life." *Dobbs*, 945 F.3d at 282 (5th Cir. 2019) (Ho, J., concurring in the judgment). It described the Act as "pure gaslighting"; it accused the Mississippi Legislature of being misogynist and racist; and it "disparage[d] the millions of Americans who believe in the sanctity of life." *Id.* at 279, 283. Putting aside the rhetoric, the district court certainly would have been within its discretion "if the district court had *permitted* discovery" too. *Id.* at 281 (emphasis in original). Instead, it chose to substitute its own misconceptions in place of the facts that Mississippi sought to present regarding the medical science and data on which the Act is based. Perhaps the abuse-of-discretion standard tolerates this process, but the legal profession should not. *Id.* at 286 (observing that "citizens

It is often overlooked that even in *Roe*, the Supreme Court acknowledged that the states "have an important and legitimate interest . . . in protecting the potentiality of human life." 410 U.S. 113, 162 (1973). However, "the Court's precedents after *Roe* … 'undervalue[d] the State's interest in potential life." *Gonzales*, 550 U.S. at 157 (quoting *Casey*, 505 U.S. at 873 (plurality opinion)). Then, in *Casey*, the Court stated flatly "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child," 505 U.S. at 846, and *Gonzales* agreed that "[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman." *Gonzales*, 550 U.S. at 157.

H.B. 1510 furthers the State's interest in protecting life by protecting unborn children from nontherapeutic abortions after the first trimester. H.B. 1510 draws a line at 15 weeks' gestational age, after which abortions are allowed only in cases of medical emergencies or severe fetal abnormalities. The 15-week mark is well supported by findings in the Act and modern medical science regarding the development of the unborn child during the first trimester.[22] The unborn child's first heartbeat occurs around 5 or 6 weeks' gestation; its physiological functions are present at 9 weeks; it's vital organs begin functioning at 10 weeks; it can move freely about the womb at 11 weeks;

may rightfully wonder whether judges are deciding disputes based on the Rule of Law or on an altogether different principle").

22. *See* Mississippi State Department of Health, *Informed Consent Information* at 3-6 (Mar. 2018), at https://www.msdh.ms.gov/msdhsite/_static/resources/7582.pdf (describing the timeline of fetal growth).

and by 12 weeks' gestation, he or she has taken on "the human form" in all relevant aspects. *Gonzales*, 550 U.S. at 160; MISS. CODE ANN. § 41-41-191, 2(b) (2018). H.B. 1510 rightly finds that, by the end of the first trimester, there is a compelling state interest in protecting the developing child.

By selecting the 15-week mark, H.B. 1510 establishes a clear boundary limiting elective abortions to the first trimester.[23] The State's interests in drawing this bright line were summarized at the end of the Senate debate on H.B. 1510: "The state of Mississippi has a compelling justification … to protect the life of the 15 week old child." H.B. 1510 Floor Debates, https://law-db.mc.edu/legislature/bill_list.php?session=2018. That child is alive; it has its own DNA system, circulatory system, and sensory system; it is recognizable as a baby with arms, legs, eyes, ears, hands, and feet; it has the ability to hear its parents' voices and respond to the outside world. In short, "this is a life worthy of protection." *Id.*

One of the consequences of the unborn child's taking on the human form is the emergence of the ability to experience pain. H.B. 1510 is the second law that the Mississippi Legislature has passed related to the

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23. Most physicians date a pregnancy using the "LMP" method, which dates the pregnancy by using the first day of the mother's last menstrual period. The other method is to date the pregnancy from fertilization. There is typically a two-week difference between these methods. For example, a 15-week "LMP pregnancy" would be a 13-week "fertilization" pregnancy. *See* Mississippi State Department of Health, *Informed Consent Information* at 3 (Mar. 2018), at https://msdh.ms.gov/msdhsite/_static/resources/7582.pdf.

inhumanity of abortion procedures at specific gestational ages. H.B. 1510 is also bolstered by the 2014 legislative findings made in H.B. 1400 to support Mississippi's law barring most abortions after 20 weeks LMP, which is now codified at Miss. Code Ann. § 41-41-131, *et seq*. *See* H.B. No. 1400, 2014 Miss. Laws Ch. 506 § 1. (H.B. 1400) contains numerous findings concerning protection of maternal health and prevention of fetal pain, recognizing "the compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that these children are capable of feeling pain[.]" *Id.* § 1(i).

Current medical evidence demonstrates that unborn children are capable of experiencing pain much earlier than viability, even weeks before the existing 20-week restriction. This evidence was thoroughly explained in the expert declaration of Dr. Maureen L. Condic, Ph.D., the Associate Professor of Neurobiology and Anatomy at the University of Utah School of Medicine and a recognized expert in neurobiology and embryology. *See* Petition Appendix 75a. Dr. Condic observed that "[t]he scientific evidence regarding the development of human brain structures is entirely uncontested in the literature" and confirms that an unborn child develops the necessary systems to "support[] a conscious awareness of pain" between 14-20 weeks LMP. *Id.* ¶ 3. Moreover, "[i]t is universally accepted that the simplest neural circuitry required to detect and respond to pain is in place by 8-10 weeks of human development." *Id.* ¶ 19. Dr. Condic concluded that "during the time period covered by the Gestational Age Act, the human fetus is likely to be capable of conscious pain perception in a manner that becomes increasingly complex over time." *Id.* ¶ 7.

Moreover, if the unborn child is aborted at this stage of the pregnancy—in the second or third trimester, after the 15-week mark set by the Act—the procedure of choice for abortion providers is the "dilation and evacuation procedure[]." Miss. Code Ann. § 41-41-191(2)(b)(i)(8) (2018); *see also Gonzales*, 550 U.S. at 135 (recognizing that "'D & E' is the usual abortion method in this trimester"). D&E involves "the use of surgical instruments to crush and tear the unborn child apart before removing the pieces of the dead child from the womb." Miss. Code Ann. § 41-41-191(2)(b)(i)(8) (2018); *see also Gonzales*, 550 U.S. at 135 (stating that D&E "causes the fetus to tear apart"). H.B. 1510 expresses the sound judgment that being torn apart limb by limb is a painful experience that should not be inflicted on an unborn child.

The district court refused to consider the evidence of fetal pain, prompting one member of the Fifth Circuit to note the irony of interpreting the Constitution to protect convicted murders from unnecessary pain but not unborn children. *Dobbs*, 945 F.3d at 280 (Ho, J. concurring in the judgment). It is an irony that should not exist in any civilized society, and in fact, the U.S. is wildly out of step with the rest of the world in this area, as it is one of only seven nations in the world that permits elective abortions throughout pregnancy.[24] The Mississippi Legislature

24. The *Washington Post* conducted a "fact checker" analysis and awarded "the elusive Geppetto Checkmark" to the fact that the United States is one of seven countries that allow elective abortions after 20 weeks of pregnancy. *See* "Is the United States one of seven countries that 'allow elective abortions after 20 weeks of pregnancy?'" *The Washington Post* (Oct. 9, 2017), at https://www.washingtonpost.com/news/fact-checker/wp/2017/10/09/is-the-united-states-one-of-seven-countries-that-allow-elective-abortions-after-20-weeks-of-pregnancy/.

rightly exercised its "wide discretion to pass legislation" and to resolve any "medical and scientific uncertainty" in favor of preventing fetal pain. *Gonzales*, 550 U.S. at 163.

III. The Mississippi Legislature has an interest in protecting women from the health risks associated with abortions after 15 weeks' gestational age.

Another legitimate state interest is "to foster the health of a woman seeking an abortion." *Casey*, 505 U.S. at 878. This Court has consistently recognized "that a State has an 'important and legitimate interest in the health of the mother that becomes compelling … at approximately the end of the first trimester.'" *Simopoulos v. Virginia*, 462 U.S. 506, 510–11 (1983) (quoting *Roe*, 410 U.S. at 163); *see also Gonzales*, 550 U.S. at 145 ("'[T]he State has legitimate interests from the outset of the pregnancy in protecting the health of the woman ….'" (quoting *Casey*, 505 U.S at 846)). This includes ensuring that abortions are performed with "maximum safety for the patient." *Simopoulos*, 462 U.S. at 519 (quotation omitted). The balancing of risks and benefits is left to legislatures: "Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends." *Gonzalez*, 550 U.S. at 166.

H.B. 1510 contains substantial findings regarding the physical and psychological risks to women who obtain abortions in the second and third trimesters. It found that most abortions after 15 weeks "are dilation and evacuation procedures." Miss. Code Ann. § 41-41-191(2)(b)(i)(8) (2018). It found that D&E procedures subject women to risks of "pelvic infection; incomplete abortions (retained

tissue); blood clots; heavy bleeding or hemorrhage; laceration, tear, or other injury to the cervix; puncture, laceration, tear, or other injury to the uterus; injury to the bowel or bladder; depression; anxiety; substance abuse; and other emotional or psychological problems." Miss. Code Ann. § 41-41-191(2)(b)(iv) (2018). It found that, when D&E procedures are performed after 15 weeks, "there is a higher risk of requiring hysterectomy, other reparative surgery, or blood transfusion." *Id.* It found that these maternal health "risks escalate exponentially as gestational age increases," becoming "greater than the risks of carrying a pregnancy to term" as the second trimester progresses. Miss. Code Ann. § 41-41-191(2)(b)(iii) (2018).[25]

Each of these findings is well supported by medical science. It is undisputed that abortion becomes riskier as the pregnancy advances and the gestational age increases.[26] Medical studies have documented the

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25. *See also* Linda A. Bartlett, *et al.*, *Risk factors for legal induced abortion-related mortality in the United States*, 103 Obstetrics & Gynecology 729 (Apr. 2004).

26. Second trimester abortions "pose more serious risks to women's physical health compared to first trimester abortions. The abortion complication rate is 3% to 6% at 12-13 weeks gestation and increases to 50% or higher as abortions are performed in the second trimester." Priscilla K. Coleman, Ph.D., *et al.*, *Late Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, 2010 J. of Pregnancy 1 (Jun. 28, 2010); Ingrid Skop, M.D., *Abortion Safety: At Home and Abroad*, 34 Issues L. & Med. 43, 45–46 (2019) (summarizing risks and explaining that "[t]he frequency of complications increases in later gestational ages due to inherently greater technical complexity related to the anatomical and physiologic changes that occur as the pregnancy advances.");

resulting complications experienced by women both during the abortion procedure and during the post-abortion recovery process.[27] One peer-reviewed medical journal article cited in H.B. 1510 found that the level of health risks to women almost quadruples between 11 weeks' and 15 weeks' gestation.[28]

In addition to these physical risks, the psychological risks are equally real. "[I]t seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained." *Gonzales*, 550 U.S. at 159. Although the psychological and mental health risks of abortion can be difficult to assess, there is substantial evidence that it causes a significant increase in the risk of mental health disorders among women.[29] Analysis of more than twenty-two studies on the

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Daniel Grossman, *et al.*, *Complications After Second Trimester Surgical and Medical Abortions*, Reproductive Health Matters, at 173, 173-82 (May 2008) (discussing higher rates of complications in second trimester); Suzanne Zane, *et al.*, *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstetrics & Gynecology at 258-65 (Aug. 2015).

27. Skop, *supra* n.26., at 44-48 (citing *inter alia* Maarit Niinimäki, *et al.*, *Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 114 Obstetrics & Gynecology 795-804 (Oct. 2009); S. Lalitkumar, *et al.*, *Mid-trimester induced abortion: A review*, 13 Hum. Rep. Update 37-52 (Jan.-Feb. 2007).

28. Bartlett, *et al.*, *supra* n.25 at 729-37 (finding that risk of maternal death from induced abortion doubled from those performed between 13-15 weeks and those performed between 16-20 weeks gestation).

29. David M. Fergusson, *et al.*, *Abortion and mental health disorders, evidence from a 30-year study*, 193 Br. J. Psychiatry 444

psychological effects of abortion confirmed this increased risk to the mother‘s mental health,[30] including an increase in suicide rates.[31] H.B. 1510, therefore, seeks to protect the "significant percentage of women" for whom "abortion marks the beginning of a tumultuous journey colored by feelings of regret, loss, sadness, depression, anxiety, suicidal behaviors, and alienation from others."[32]

IV. The Mississippi Legislature has an interest in protecting the integrity of the medical profession.

A corollary to the legislature's prerogative to protect unborn life and women's health is its interest in regulating

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(Dec. 2008). As one expert observes: "Many interpret the 'relief' a woman feels with the resolution of the pregnancy crisis to mean that there could be no mental harm from the procedure. Yet, an increasing body of evidence shows that over time, the feeling of relief declines, and the feeling of negative emotions related to the abortion increase." Skop, *supra* n.26 at 51.

30. "A meta-analysis of 22 studies found a moderate to highly increased risk (81% over-all) of mental health problems after abortion. Specifically, it found 34% increased risk of anxiety 37% increased depression, 110% increased alcohol abuse, 230% increased marijuana abuse, and 155% increased suicidal behavior." Skop, *supra* n.26. at 52. *See also* Priscilla K. Coleman, Ph.D, *Deriving Sensible Conclusions From the Scientific Literature on Abortion and Women's Mental Health*, Peace Psychology Perspectives on Abortion 74-93 (2016).

31. "New Study: Elevated Suicide Rates Among Mothers after Abortion," Charlotte Lozier Institute (Sept. 10, 2019), at https://lozierinstitute.org/new-study-elevated-suicide-rates-among-mothers-after-abortion/.

32. Priscilla K. Coleman, Ph.D., *Negative Abortion Experiences: Predictors and Development of the Post-Abortion Psychological and Relational Adjustment Scale*, 33 Issues L. & Med. 133, 134 (2018).

those responsible for performing the abortion procedure itself. This Court has confirmed that the legislature may "regulat[e] the medical profession in order to promote respect for life" (*Gonzales*, 550 U.S. at 158), which is an extension of the state's well-established "interest in protecting the integrity and ethics of the medical profession." *Washington v. Glucksberg,* 521 U.S. 702, 731 (1997); *see also Barsky v. Board of Regents of Univ. of N. Y.,* 347 U.S. 442, 451 (1954) (indicating the State has "legitimate concern for maintaining high standards of professional conduct" in the practice of medicine). Legislative findings about the brutality of an abortion procedure and the way it affected both the unborn child and the doctor performing the abortion were emphasized by the Court in distinguishing the federal ban at issue in *Gonzales* from the Nebraska statute struck down in *Stenberg v. Carhart*, 530 U.S. 914 (2000). *See Gonzales*, 550 U.S. at 141. Preventing inhumane abortion procedures furthers the State's legitimate interest in promoting respect for life, including the life of the unborn, and it also protects the ethics of the medical profession from the dehumanizing effects of performing such procedures. *Id.* at 156-58.

H.B. 1510 furthers the State's legitimate interests in life and the medical profession. This is because of the prevalence of D&E abortions after the first trimester. "No one would dispute that, for many, D & E is a procedure itself laden with the power to devalue human life." *Gonzales*, 550 U.S. at 158. In fact, it can be "as brutal, if not more, than" the partial-birth abortion procedure that *Gonzales* held was appropriately banned by Congress. *Id.* at 160. H.B. 1510 simply recognizes the fact that D&E is no more humane today than it was in 2007 and rightly

finds "that the intentional commitment of such acts for nontherapeutic or elective reasons is a barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession." MISS. CODE ANN. § 41-41-191(2)(b)(i)(8) (2018). H.B. 1510 is, therefore, a valid expression of the State's interest in mitigating "the effects on the medical community and on its reputation caused by" the predominant method of abortion used after the first trimester. *Gonzales*, 550 U.S. at 157.

V. The Mississippi Legislature did not impose an undue burden on women.

All of these important state interests exist pre-viability, which is why an absolute right to a pre-viability abortion is not tenable. As the Petitioners' brief explains, viability is not an appropriate standard for assessing abortion regulations. It is an arbitrary line that improperly disregards the State's interests based on an outdated understanding of the development of the unborn child and the maternal health risks from abortions.

The problems with the viability standard are particularly evident here, where it was invoked to invalidate a state law that poses no undue burden on women seeking abortions in Mississippi. As this case involves a facial challenge to H.B. 1510, the inquiry is whether "it will operate as a substantial obstacle to a woman's choice to undergo an abortion in a large fraction of the cases in which [it] is relevant." *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103, 2132 (2020); *see also id.* at 2135 (Roberts, C.J., concurring in the judgment) ("A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect

of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."). H.B. 1510 prohibits nontherapeutic abortions after 15 weeks' LMP. So, assuming arguendo that the undue burden standard applies, the question is whether the 15-week mark poses a substantial obstacle to a large fraction of women seeking nontherapeutic abortions of nonviable fetuses.

The answer is no. As a practical matter, a woman who wants to abort a nonviable fetus in Mississippi currently has a *de facto* 16-week time-period in which to make that decision because "no facility in Mississippi provides abortions after 16 weeks LMP." *Dobbs*, 945 F.3d at 277. The practical effect of the Act is to reduce the period during which a nonviable unborn child may be aborted from 16 weeks to 15 weeks. The district court cited no evidence (because none exists) that a 15-week decision-making period is a substantial obstacle to a large fraction of women seeking nontherapeutic abortions in Mississippi. There is simply no reason to conclude that a woman cannot make a decision regarding the termination of her pregnancy within the first 15 weeks of gestation. The Legislature has ensured that any woman interested in abortion (or other options) has access to a wealth of information and resources to inform and assist her decision-making process during the first 15 weeks. *Supra* Part I.A. That the vast majority of women who choose abortion in Mississippi (over 90 percent) do so in the first trimester[33] confirms that sufficient resources are available

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33. In 2017, only 90 women had abortions at Respondent JWHO after 15 weeks LMP. *Dobbs*, 945 F.3d at 273 n.31. This group of women makes up approximately 3.6% of the women who obtain abortions at JWHO annually, and only 2% of the 4,289 women in Mississippi who had abortions in 2017 (whether in- or out-of-state). *See* "Abortion

to enable women to make a fully informed choice before the 15-week mark, and this choice remains unfettered by the Act.[34]

For women who choose life, the Legislature has ensured access to a number of resources to support them during pregnancy, including family planning, pre-natal care, and information regarding options and available services from public and private resources. *Supra* notes 6-11. Of course, exigent circumstances may arise in the

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Reporting: Mississippi (2017), Charlotte Lozier Institute, at https://lozierinstitute.org/abortion-reporting-mississippi-2017/. This data is consistent with historic trends across other states too: "About 90% of all abortions performed in the United States take place during the first trimester of pregnancy, before 12 weeks of gestational age." *Stenberg*, 530 U.S. at 923 (citing Centers for Disease Control and Prevention, Abortion Surveillance—United States, 1996, p. 41 (July 30, 1999); *see also Gonzales*, 550 U.S. at 134 (noting that between 85 to 90 percent of abortions take place in the first trimester); "Induced Abortion in the United States – Fact Sheet," Guttmacher Institute (Sept. 2019), at https://www.guttmacher.org/fact-sheet/induced-abortion-united-states (stating that 88% of abortions are performed in the first twelve weeks LMP).

34. The same conclusion follows even under the district court's finding that "viability typically begins between 23 to 24 weeks lmp." *Currier*, 349 F. Supp. 3d at 539-40. The district court made no findings that the Act poses an undue burden to any woman seeking an abortion between 15 and 24 weeks LMP in Mississippi. Moreover, Mississippi reported only five abortions between 17-20 weeks in 2017 and three in 2018, again demonstrating that women are able to make an abortion decision in the first trimester. "Abortion Reporting: Mississippi (2017)," Charlotte Lozier Institute, at https://lozierinstitute.org/abortion-reporting-mississippi-2017/; "Abortion Reporting: Mississippi (2018), Charlotte Lozier Institute, at https://lozierinstitute.org/abortion-reporting-mississippi-2018/.

second and third trimester, which is why H.B. 1510 provides exceptions for women who need later-term abortions due to medical emergencies.[35] This provision exempts those abortions that may be necessary to preserve the life or health of the mother using a definition carefully modeled on the "medical emergency" exemption endorsed by eight Justices in *Casey*.[36] H.B. 1510 appropriately contemplates

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35. The Act defines "medical emergency" as a:

> condition in which, on the basis of the physician's good faith clinical judgment, an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition arising from the pregnancy itself, or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function.

Miss. Code Ann. § 41-41-191(3)(j) (2018).

36. *Casey* considered a challenge to a Pennsylvania statute mandating procedures that would delay, and could prevent, abortions, such as a 24–hour waiting period and mandatory parental consent for minors. *See Casey*, 505 U.S. at 845. The Court upheld the statute's life/health exception that allowed women to circumvent the statute's requirements in the event of a "medical emergency," defined as a

> condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Id. at 879. Justices Kennedy and Souter joined Justice O'Connor's plurality opinion that upheld the medical exemption after

and exempts a broader range of risks than the provision in *Casey* as a result of the broader scope of H.B. 1510's regulation.[37] Even without its similarities to the exemption

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construing the exemption's language "will create serious risk of substantial and irreversible impairment of a major bodily function" to encompass conditions that "could lead to an illness with substantial and irreversible consequences." *Id.* at 880 (quoting *Planned Parenthood of Se. Pennsylvania v. Casey*, 947 F.2d 682, 700–01 (3d Cir. 1991)). Justice Blackmun's concurrence joined the plurality's holding on this point. *Id.* at 922. And while Chief Justice Rehnquist's dissent, joined by Justices White, Scalia, and Thomas, vehemently disagreed with large swathes of the plurality opinion, it nonetheless endorsed the plurality's affirmation of the medical emergency exemption. As the Chief Justice explained:

> We observe that Pennsylvania's present definition of medical emergency is almost an exact copy of that State's definition at the time of this Court's ruling in *Thornburgh* [*v. Am. Coll. of Obstetricians & Gynecologists*], one which the Court made reference to with apparent approval. We find that the interpretation of the Court of Appeals in these cases is eminently reasonable, and that the provision thus should be upheld.

Id. at 978-79 (citing *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 771 (1986)).

37. For example, the medical emergency provision upheld in *Casey* requires a physician find a condition that makes an "immediate abortion" necessary to preserve a mother's life or a condition that creates a serious risk of substantial and irreversible impairment from "a delay" to exempt the mother's compliance with the delay required by Pennsylvania's statute. In contrast, H.B. 1510 provides a broader medical emergency exemption corresponding to the broader regulation in the statute. The Act's exemption only requires that a physician find that due to a condition "an abortion is necessary" (whether immediate or

upheld in *Casey*, the wording of the Act's exemption is integral to "the balance of risks [that is] within the legislative competence" of the Mississippi Legislature where, as here, "the regulation is rational and in pursuit of legitimate ends." *Gonzales*, 550 U.S. at 166.

Ultimately, H.B. 1510 encourages women to choose life—to exercise their "rights to conceive and to raise [their] children," which are "essential" and "basic civil rights." *Stanley v. Illinois*, 405 U.S. 645, 652 (1972). Requiring this decision to be made within the first 15 weeks is just one step—albeit a critical one—in the care and upbringing of the child, which is why Mississippi has ensured that support for families does not end at birth but rather extends throughout the child-rearing years. This is why Mississippi actively supports families who need help to provide their children with proper nutrition, healthcare, daycare, and education. This is why Mississippi fosters partnerships with private organizations that serve disadvantaged families in local communities. This is why Mississippi has increased funding for foster care and adoption programs to respond to circumstances in which the birth parents are not able to raise the child. No one would contend that the burdens of life can be eliminated, but they can be alleviated when a community is incentivized to value all lives and to share the associated burdens, rather than ending lives that are perceived to be too burdensome.

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not) to preserve a mother's life or that creates a serious risk of substantial and irreversible impairment from "the continuation of the pregnancy" (not just from "a delay").

CONCLUSION

The Court should uphold the Act as a legitimate exercise of the State's substantial interests in protecting unborn life, women's health, and the integrity of the medical profession.

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