No. 18-483

In The Supreme Court of the United States

KRISTINA BOX, COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, ET AL.,

Petitioners,

v.

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC., ET AL.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF OF THE RESTORATION PROJECT; PASTOR JOSEPH PARKER, PASTOR OF GREATER TURNER CHAPEL A.M.E. CHURCH; EVERLASTING LIGHT MINISTRIES; PROTECT LIFE AND MARRIAGE TEXAS; AND THE THOMAS MORE SOCIETY AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICI CURIAE[1]

The Restoration Project ("TRP") is a non-profit organization dedicated to rebuilding families, promoting the sanctity of life, and providing related educational materials, in order to transform American public policy and culture's impact on Black life. TRP works with pastors, ministry leaders and organizations to restore a culture of uprightness, evenhandedness, and virtue.

Pastor Joseph Parker, pastor of Greater Turner Chapel A.M.E. Church in Greenwood, MS, has served as a pastor of different congregations for a little more than 40 years. He has been working to stand up for life against abortion for more than 20 years and is disturbed by the abortion industry's deliberate targeting of the African American community.

Everlasting Light Ministries is a comprehensive post-abortion healing and marriage ministry that seeks to heal the massive devastation of abortion and marital discord in America and especially in communities of color; proclaim the truth about abortion and its real life consequences; and sensitize communities to the needs of all post-abortive, post-miscarriage people.

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[1] Counsel for Petitioners and Respondents received timely notice of amici curiae's intent to file this brief and counsel for Petitioners and Respondents have consented to its filing. Further, as required by Supreme Court Rule 37.6, counsel certifies this brief was not authored, in whole or in part, by counsel to a party, and no monetary contribution to the preparation or submission of this brief was made by any person or entity other than amici curiae, their members, or their counsel.

Protect Life and Marriage Texas works to uphold the Judeo-Christian ethic established by our Founding Fathers in our society with the view of securing liberty for marriages, the American family and the life of the unborn.

The **Thomas More Society** ("TMS") is a national public interest law firm devoted to restoring respect in the law for life, the family and religious liberty. Based in Chicago, TMS accomplishes its organizational mission through litigation, education, and related activities.

INTRODUCTION AND SUMMARY OF ARGUMENT

Amici The Restoration Project, Pastor Joseph Parker, pastor of Greater Turner Chapel A.M.E. Church, Everlasting Light Ministries, Protect Life and Marriage Texas, and the Thomas More Society submit this brief to aid the Court in assessing the gravity of the problem Indiana's HEA 1337 and similar state statutes seek to address. Invidious discrimination in the provision of abortion services is an entrenched and escalating phenomenon. Babies of minority mothers are aborted at a far higher rate than their white counterparts—a disturbing trend that the abortion industry intentionally and unabashedly perpetuates. With recent advances in prenatal testing technology, abortions motivated by the unborn child's gender, disability, and

other disfavored genetic traits are also dramatically on the rise.

HEA 1337 and similar state laws are sensible and important legislative responses to racist, sexist, and eugenic practices performed under the guise of "reproductive rights." This Court should grant certiorari in order to reverse the Seventh Circuit and reinstate HEA 1337.

ARGUMENT

I. The Delivery of Abortion Services is Infected with Racial Bias.

A. The origins of abortion are racist and eugenic.

The eugenic origins of the birth-control movement—the progenitor of the abortion rights movement—are well-established. *See*, *e.g.*, Rebecca A. Messall, *Margaret Sanger and the Eugenics Movement*, HUMAN LIFE REV., Spring 2010, at 98 (noting that the founders and early leaders of what became Planned Parenthood were all members of the American Eugenics Society). Margaret Sanger, the founder of the birth control organization that became Planned Parenthood, wrote:

> [T]he example of the inferior classes, the fertility of the feeble-minded, the mentally defective, the poverty-stricken classes, should not be held up for emulation to the mentally and physically fit though less fertile parents of the educated and well-to-do classes. On the

> contrary, **the most urgent problem today is how to limit and discourage the over-fertility of the mentally and physically defective**.

Margaret Sanger, *The Eugenic Value of Birth Control Propaganda*, BIRTH CONTROL REV., Oct. 1921, at 5, available at https://www.nyu.edu/projects/sanger/webedition/app/documents/show.php?sangerDoc=238946.xml.

Scholars of the history of the eugenics movement acknowledge that Sanger "supported some eugenic aims, and was not above voicing her contempt for the poor, disabled and minorities." Paul A. Lombardo, *Symposium Article: Disability, Eugenics, and the Culture Wars*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 57, 76 (2008). They also acknowledge that in Planned Parenthood's early advocacy for birth control, "[t]he organization focused on unwanted children and pathological parenting in poor African American communities. . . ." Mary Ziegler, 25 YALE J.L. & FEMINISM 1, 13 (2013); *see also Birth Control or Race Control? Sanger and the Negro Project*, Newsletter #28 (The Margaret Sanger Papers Project, New York University, New York, N.Y.), Fall 2001 (conceding that "the patriarchal racism of the time . . . dictated both the Federation's and Sanger's approach to blacks and birth control"), https://www.nyu.edu/projects/sanger/articles/bc_or_race_control.php. To early advocates of birth control and abortion, minority racial groups were among "the mentally and physically defective" whose fertility they sought to limit.

B. The modern abortion industry continues to target ethnic minorities.

Modern advocates of abortion disavow the racism of Planned Parenthood's founders. *See*, *e.g.*, Now This News, Group Nine Media, Inc., Video: *The History of 100 Years of Women's Health Care at Planned Parenthood*, Jan. 17, 2017, https://www.youtube.com/watch?v=VqYspn7PZmQ (acknowledging that "there's no question that Margaret left behind a conflicting legacy" but asserting that "*[r]acism and ableism do not have a place at Planned Parenthood and sure as [expletive] don't represent the organization's commitment to equality*").

Demographic data tell a different story. Minority babies in America are at far greater risk from abortion than white babies. In parts of this country, black babies are more likely to be aborted than they are to be born alive. *See*, *e.g.*, N.Y. STATE DEP'T OF HEALTH, TABLE 23: INDUCED ABORTION AND ABORTION RATIOS BY RACE/ETHNICITY AND RESIDENT COUNTY NEW YORK STATE—2013, VITAL STATISTICS OF N.Y. STATE 2013, *available at* https://www.health.ny.gov/statistics/vital_statistics/2013/table23.htm (noting that in New York City in 2013, 1180 black babies were aborted for every 1000 live births, compared to 240 white babies). In 2014, the rate of abortion among black women was 3.5 times the abortion rate among white women. *See* Tara C. Jatlaoui et al., *Ctrs. for Disease Control & Prevention, Abortion Surveillance—2014, Morbidity and Mortality Weekly Report*, Vol. 66, No. 24 (Nov. 24, 2017), at 1-48, *available at* https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.

htm ("CDC"). In Indiana in 2017, 9.7% of the state population was black but black women had 30.6% of the state's abortions. *See* INDIANA STATE DEP'T OF HEALTH, TERMINATED PREGNANCY REPORT 2017 10, *available at* https://www.in.gov/isdh/files/2017%20Indiana%20Terminated%20Pregnancy%20Report.pdf; UNITED STATES CENSUS BUREAU, QUICK FACTS: INDIANA, https://www.census.gov/quickfacts/in (last visited Nov. 8, 2018). The numbers are similarly grim for Hispanic babies. *See*, *e.g.*, N.Y. STATE DEP'T OF HEALTH, *supra* (610 Hispanic babies were aborted per 1000 live births in New York City in 2013, compared to 240 white babies).

Abortion advocates contend that preexisting cultural and socioeconomic factors have caused these racial disparities. *See*, *e.g.*, Preterm, *A Commitment to Racial Justice* (2018), www.preterm.org/racial-justice ("Because of racial injustice, women of color are both more likely to need abortions, and less likely to be able to afford them. For us, reproductive justice includes racial justice."). By the industry's account, its provision of abortion in significantly higher rates to minority women than to white women is a beneficent response to the minority population's greater "need," rather than a function of anything that the abortion industry has done to inflate demand in the minority population. But these claims are belied by the industry's business and marketing practices.

A study based on 2010 Census data reveals that Planned Parenthood has located 79% of its surgical abortion centers within walking distance of

minority-dense neighborhoods. *See* Susan W. Enouen, Life Issues Institute, *New Research Shows Planned Parenthood Targets Minority Neighborhoods*, LIFE ISSUES CONNECTOR (Oct. 2012), http://www.protectingblacklife.org/pdf/PP-Targets-10-2012.pdf; *see also* Mark Crutcher et al., Life Dynamics Inc., *Racial Targeting and Population Control* 22, 2011, https://issues4life.org/pdfs/racial_targeting_population_control.pdf (reporting based on census-based study of family planning clinics that "there is not one state in the union without population control centers located in zip codes with higher percentages of blacks and/or Hispanics than the state's overall percentage").[2]

Planned Parenthood claims that locating their clinics near minority communities is part of their outreach to those most in "need" of their services. *See*, *e.g.*, Hilary Cadigan, *Planned Parenthood moves to EAV*, CREATIVE LOAFING, June 16, 2017, https://creativeloafing.com/content-266693-Planned-Parenthood-moves-to-EAV ("Rollins School of Public Health graduate students from Emory University conducted a relocation analysis to identify strategic locations for the Atlanta

[2] Planned Parenthood tried to counter this analysis of the Census data with a Guttmacher Institute study allegedly finding that only a small percentage of Planned Parenthood clinics are located in "majority-black neighborhoods," but Guttmacher's study was carefully manipulated to produce a misleading result. *See* Willis L. Krumholz, *Yes, Planned Parenthood Targets and Hurts Poor Black Women*, THE FEDERALIST, Feb. 18, 2016, http://thefederalist.com/2016/02/18/yes-planned-parenthood-targets-and-hurts-poor-black-women/ (explaining the defects in the Guttmacher data and its misinterpretation by defenders of Planned Parenthood).

health center. The East Atlanta site is located in an area of need for our sexual and reproductive health services. . . .”). But community health centers, which provide medical services to low-income patients, are not similarly concentrated in minority neighborhoods; they perceive needs for their services in other communities as well. *See* Charlotte Lozier Institute, *Maps: Health Clinics Nationwide Compared to Planned Parenthood Centers*, Aug. 21, 2015, https://lozierinstitute.org/health-clinics-nationwide-compared-to-planned-parenthood-centers/. Only a provider that receives the lion’s share of its revenues as payment for abortions has made the deliberate strategic choice to locate its surgical abortion clinics near high-density minority communities. Willis L. Krumholz, *Planned Parenthood’s Big Bad Business Model*, THE FEDERALIST, Oct. 27, 2015, http://thefederalist.com/2015/10/27/planned-parenthoods-big-bad-business-model/ (“revenue from abortion provides the highest profit margins, and is the biggest contributor to [Planned Parenthood] affiliates’ total profit”).

Since Planned Parenthood began to concentrate its abortion services intentionally in minority communities, the number of minority abortions has dramatically increased while the abortion rate among white women has declined. *See* Susan W. Enouen, Life Issues Institute, *More Evidence Planned Parenthood Markets Abortion to Minorities*, June 14, 2016, https://www.lifeissues.org/2016/06/pp-markets-abortion-minorities/ (“[F]rom 1990 to 2008, before and after Planned Parenthood’s reinvention, the percentage of abortions

received by Black women increased by 9.0%; for Hispanic women it rose 7.6% while the percentage of abortions received by white women declined by 11.1%."). Not coincidentally, during the same interval, Planned Parenthood's revenues have skyrocketed. *See* Willis L. Krumholz, *Guttmacher Erases Data To Protect Planned Parenthood, IUDs*, THE FEDERALIST, Apr. 12, 2016, http://thefederalist.com/2016/04/12/guttmacher-erases-data-to-protect-planned-parenthood-iuds/ (exposing the Guttmacher Institute's manipulation of data to mask the fact that Planned Parenthood had increased its profits by altering its business model in such a way as to bring about a dramatic increase in minority abortion rates).

In addition to deliberately situating their abortion clinics close to minority communities, Planned Parenthood also makes a concerted marketing effort to encourage such communities to avail themselves of its abortion services. For example, Planned Parenthood's "Black Community" Twitter feed makes public statements encouraging black women to support and patronize Planned Parenthood, such as: "If you're a Black woman in America, it's statistically safer to have an abortion than to carry a pregnancy to term or give birth." @PPBlackComm, Twitter, Oct. 31, 2017, 8:13 AM, https://twitter.com/ppblackcomm/status/925380307242582016?lang=en.

Given its strategic location of abortion clinics near minority neighborhoods and its blatant marketing of abortion to the minority community, the abortion industry's claims to bear no responsibility for the

staggering numbers of minority abortions beggars belief. *See* Crutcher et al., *supra* (noting that "these patterns are routinely considered indicative of racial targeting when it comes to other issues," such as when civil rights advocates criticize tobacco and alcohol companies for concentrating their retail and marketing efforts disproportionately in minority neighborhoods).

C. Socioeconomic factors alone do not explain the different treatment of racial minorities.

Abortion is not the only instance of the medical community treating minority patients differently from their white counterparts. In a 2002 study, the Institute of Medicine ("IOM") found that "[e]vidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services." INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 5 (2002), *available at* https://www.nap.edu/read/10260/chapter/1#ii ("IOM"); *see also* Tara Culp-Ressler, *Challenging Medical Racism and Physicians' Preference for White Patients*, THINK PROGRESS, Feb. 23, 2015, https://thinkprogress.org/challenging-medical-racism-and-physicians-preference-for-white-patients-59bec589df88/.

Such disparities are not attributable to socioeconomic differences, the IOM observed: "The majority of studies . . . find that racial and ethnic disparities remain even after adjustment for socioeconomic

differences and other healthcare access-related factors." *Id.*; *see also* Erin Peterson et al., *Why childbirth is a death sentence for many black moms*, Oct. 13, 2018, https://www.11alive.com/article/news/investigations/mothers-matter/why-childbirth-is-a-death-sentence-for-many-black-moms/85-604079621 ("Black women die at higher rates regardless of their education, how much money they make or preexisting conditions."). Rather, research suggests "that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity." IOM, *supra*, at 11. Among other studies, the IOM cited one that "found that doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account." IOM, *supra*, at 11.

Planned Parenthood itself has decried the racial disparities in the delivery of healthcare services and has acknowledged that such disparities cannot be explained solely by socioeconomic factors:

> [E]ven after accounting for socioeconomic factors, educated, middle-class Black women were found to be at even higher risk of having smaller, premature babies with a lower chance of survival. A growing body of research is linking racism-related stress and chronic worry about racial discrimination with Black-White

> disparities. The U.S. has a legacy of reproductive oppression which may cause some women to delay getting care. And unconscious bias may also play an important role.

Birth Outcome Disparities Among Black Women, PLANNED PARENTHOOD OF THE PACIFIC SOUTHWEST, INC., BLOG (Mar. 2, 2018, 11:04 PM), https://www.plannedparenthood.org/planned-parenthood-pacific-southwest/blog/birth-outcome-disparities-among-black-women.

In Planned Parenthoods's narrative, abortion is always described as part of the *solution* to these disparities—not part of the problem. *See id.* (recommending "reproductive life planning and pre-conception care services offered at [Planned Parenthood]" as part of the path "to better birth outcomes for Black women"); *see also* Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POLICY REVIEW 3, Aug. 6, 2008, *available at* https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture. Abortion advocates never acknowledge that the correlation of the concentration of abortion clinics near minority communities with *increasing* unintended pregnancy and abortion *in those same communities* suggests at least that "reproductive life planning" services are not *improving* outcomes for minority women.

In fact, the correlation between increased access to abortion services and poorer health outcomes suggests that the abortion industry is harming those women. Despite the barriers to collecting data about abortion, scientists are increasingly able to document

connections between abortion and the negative health outcomes that afflict minority communities. *See*, *e.g.*, Brent Rooney et al., *Does Induced Abortion Account for Racial Disparity in Preterm Births, and Violate the Nuremberg Code?*, J. AM. PHYS. & SURGEONS, Winter 2008, at 102, *available at* http://www.jpands.org/vol13no4/rooney.pdf (documenting a link between preterm birth and prior induced abortion). Occasionally, extreme instances of such outcomes even appear in the media. *See*, *e.g.*, Rosemary Parker, *Dead woman's ultrasound showed clot, problems after abortion, records show*, MICHIGANLIVE, Apr. 13, 2017, https://www.mlive.com/news/kalamazoo/index.ssf/2017/04/dead_womans_ultrasound_showed.html (documenting the death of a young black woman after an abortion at Planned Parenthood); Matthew Hay Brown, *Abortion opponents want tighter regulations*, THE BALTIMORE SUN, Mar. 2, 2011, https://www.baltimoresun.com/bs-mtblog-2011-03-abortion_opponents_want_tighte-story.html (reporting tragic outcomes after abortion, including the death of a young black woman).

Perhaps it is unsurprising that abortion advocates deny that racial bias could infect the abortion industry, but there is no objective reason to doubt that racial bias exists at least as much in that industry as it does everywhere else. Just like other medical treatments, the available data confirm that the racial disparities in the incidence of abortion are not reducible to socioeconomic disparities. There are roughly twice as many poor white women in the United States as there are poor black women, and yet poor black women account

for more of the nation's abortions (14.1%) than poor white women do (11.7%). *See* Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 OBST. & GYN. 1358-66 (June 2001). Thus, poverty can't be the whole story. Disparities in access cannot be a sufficient explanation either, since Planned Parenthood has made its services even more available to minority populations than to disadvantaged members of other groups, and its efforts have not slowed the increasing rate of minority abortions.

It is widely acknowledged that—consciously or unconsciously—the medical community treats minority patients differently than it treats similarly-situated white patients. There is no reason to believe that there is any *less* racism at work in the abortion context. Moreover, considering the abortion industry's history as an explicitly racist social movement, its unapologetic targeting of minority communities even to this day, and the increasingly poor health outcomes of the communities it claims to serve, there is every reason to believe that racism plays a profound role in the delivery of abortion services. *See* TooManyAborted.com, *The Negro Project*, http://www.toomanyaborted.com/thenegroproject/ (last visited Nov. 13, 2018) (noting the continuing effects of Margaret Sanger's "Negro Project" on today's black communities); Tanya L. Green, *The Negro Project: Margaret Sanger's EUGENIC Plan for Black America*, BLACKGENOCIDE.ORG, http://www.blackgenocide.org/archived_articles/negro.html (last visited Nov. 13,

2018) (describing the Negro Project and its unfortunate ongoing legacy).

II. Sex-Selection Abortions are a Reality in the United States.

Abortions for the purpose of eliminating a baby of an undesired sex occur frequently in the United States. Because women seeking abortions are not routinely required to declare their motivation, there are no statistics showing precisely how often sex selection is a motive, or the only motive, in seeking an abortion. *See* Sujatha Jesudason & Susannah Baruch, *Sex Selection: What Role for Providers*, 86 CONTRACEPTION 6, 597 (2012), *available at* https://www.contraceptionjournal.org/article/S0010-7824(12)00796-2/pdf (acknowledging lack of "official data on the frequency of pre- or during-pregnancy sex selection," but provider experience and media coverage indicating it is a common practice). But data from the few groups with a known single-gender preference, widespread acceptance of other types of sex-selective reproductive technology, and mainstream defense of the right to sex-selective abortion all demonstrate that sex-selective abortion is a reality in the United States.

A. Available statistics reflect widespread use of sex-selective abortion.

Sex-selective abortion is not typically detectible in birth rate statistics because it can be used to eliminate either sex, but where a cultural group has a

single-gender preference, the results of sex-selection abortion can be seen in altered sex ratios at birth (SRBs). Studies of data from the "Asian-Pacific" population, which is characterized by "son-preference," from the 2000 census revealed "[n]aturally impossible SRBs within particular ethnic groups. . . ." Nicholas Eberstadt, *The Global War Against Baby Girls*, THE NEW ATLANTIS, Fall 2011, *available at* https://www.thenewatlantis.com/publications/the-global-war-against-baby-girls. In other words, the sex-ratios at birth of the children of Americans of Asian-Pacific origin were skewed so far from what is naturally possible that the use of sex-selection to avoid the birth of daughters is undeniable. Moreover, the sex-ratios at birth became more sharply distorted among babies later in birth-order, which "strongly suggest[s] that sex-selective abortions were the driver." *Id.*; Jason Abrevaya, *Are There Missing Girls in the United States? Evidence from Birth Data*, 1 AM. ECON. J.: APPLIED ECON. 2, 1, 3, 7, 15, 25-26 (2009), *available at* https://pdfs.semanticscholar.org/8f71/b2fb8f1184351113414f5d4201e02fb70e95.pdf (concluding that Chinese and Indian parents were more likely to have a son at their third and fourth births than the other ethnic groups that were studied); Kelsey Harkness, *Sex Selection Abortions are Rife in the U.S.*, NEWSWEEK, Apr. 14, 2016, *available at* https://www.newsweek.com/sex-selection-abortion-rife-us-447403; *see also* Sunita Puri et al., "*There Is Such a Thing as Too Many Daughters, but Not Too Many Sons*": *A Qualitative Study of Son Preference and Fetal Sex Selection Among Indian Immigrants in the United States*, 72 SOC. SCI. & MED. 1169 (2011) (study of 65 Indian

immigrant women "found that 40% of the women interviewed had terminated prior pregnancies with female fetuses and that 89% of women carrying female fetuses in their current pregnancy pursued an abortion").

Although statistics can only reflect the practice when there is a single gender preference, there is no reason to believe that only women in cultures with a "son-preference" have availed themselves of sex-selective abortion in the United States. Medical providers in the United States often cater to the preferences of prospective parents to achieve a certain "family balance" in terms of number and gender of children. Jesudason & Baruch, *supra*, at 597 (elaborating on "family balancing" as a motive for sex selection). This "family balancing" motivation for sex-selective abortions exists wherever pre-natal diagnosis and abortion are both available, and its prevalence is evident in the lucrative "reproductive technology" industry.

B. Americans freely make use of reproductive technologies for the purpose of selecting a child of a particular sex.

Although abortions for the purpose of sex-selection are not susceptible to data tracking, it is well established that Americans embrace several other reproductive technologies for the purpose of choosing a future baby's sex, including one that, like abortion, ends the lives of one's own already-conceived genetic offspring. A lucrative industry has developed around

offering prospective parents the ability to select their baby's gender via pre-implantation genetic diagnosis ("PGD"). Jasmeet Sidhu, *How to Buy a Daughter: Choosing the sex of your baby has become a multi-million-dollar industry*, SLATE.COM, Sept. 14, 2012, *available at* http://www.slate.com/articles/health_and_science/medical_examiner/2012/09/sex_selection_in_babies_through_pgd_americans_are_paying_to_have_daughters_rather_than_sons_.html ("Gender selection now rakes in revenues of at least $100 million every year.").

PGD refers to the testing of embryos generated by in vitro fertilization for particular traits. *Id.* Once the embryos are sorted by trait, parents may choose which to implant in a women's uterus in order to bear a baby with the desired characteristic. PGD is used throughout the world for diagnostic purposes, but the United States is one of the only countries in which PGD is legal for non-medical reasons such as sex-selection. *Id.* ("It is illegal for use for nonmedical reasons in Canada, the U.K., and Australia."); Michelle J. Bayefsky, *Comparative preimplantation genetic diagnosis policy in Europe and the USA and its implications for reproductive tourism*, 3 REPROD. BIOMEDICINE & SOC. ONLINE 41 (2016) ("The USA stands apart in its laissez-faire approach towards the use of PGD."). Accordingly, the United States has become a destination for "medical tourism" in this area.

A 2004 study found that 40% of Americans had no concern about PGD as a means of selecting the gender of future children. GENETICS & PUBLIC POLICY CENTER,

REPRODUCTIVE GENETIC TESTING: WHAT AMERICA THINKS 11 (2004), *available at* https://jscholarship.library.jhu.edu/bitstream/handle/1774.2/976/ReproGenTestAmericaThinks.pdf?sequence=1&isAllowed=y. "A 2006 survey by Johns Hopkins University found that 42 percent of fertility clinics offered PGD for gender selection. . . . [And] that was . . . before many clinics undertook aggressive online marketing campaigns to drive the demand." Sidhu, *supra*; *see also* Bayefsky, *supra* ("Elective sex selection is reported to account for 9% of PGD uses in the USA."). PGD is popular with women because unwanted embryos are destroyed prior to implantation in the uterus, which avoids the need for a physically and emotionally taxing abortion. However, PGD is by no means easy: it involves medical procedures to harvest eggs and implant embryos; it is extremely costly; and it does not always yield viable embryos. *See*, *e.g.*, Sidhu, *supra*.

A less invasive and less costly method of trying to pre-select a baby's sex is "sperm sorting," which involves centrifugally sorting a sperm sample by weight into groups of sperm that are more or less likely to include a Y chromosome, then using a preferred group of sperm for IVF or artificial insemination. World Health Org. Genomic Resource Ctr., *Gender and Genetics: Genetic Technologies for Sex-Selection, Prefertilization,* http://www.who.int/genomics/gender/en/index4.html (last visited Nov. 13, 2018). This method of gender selection is far less invasive than PGD and far less expensive, but it is also far less reliable, with success rates of only 75 to 85%. *Id.*

Sperm sorting is widely available in the United States, but at $1500 per attempt, it is still out of reach to most prospective parents, and, in up to 25% of cases, it yields an unwanted child of the opposite sex. *See id.*; *see also*, *e.g.*, Sidhu, *supra* (detailing the history of a mother who tried sperm sorting to achieve a female child, conceived a male she considered aborting, then went into debt for two rounds of IVF and PGD).

The demand within the United States for procedures such as PGD and sperm-sorting evidences a societal embrace of using reproductive technology for sex-selection. A culture in which the wealthy are engaging in PGD and sperm-sorting undoubtedly includes many who are pursuing the same result through the less costly means of sex-selective abortion.

C. Unlike most of the world, American abortion activists defend the choice to abort a fetus because of a preference for the other sex.

Fearing any narrowing of a woman's right to choose abortion, abortion proponents in the United States and the United Kingdom openly call for protecting the right to abort because of a preference for one sex or another: "If the U.S. Supreme Court thinks sex selection is sexist, more states will begin to chip away at a woman's reasons for terminating her pregnancy." Sital Kalantry, *Challenging the Narrative on Sex-Selective Abortion Bans*, MS. MAGAZINE BLOG (Aug. 25, 2017). They recognize the inconsistency between

viewing abortion as an absolute right and prohibiting certain reasons for choosing abortion: "Banning sex-selective abortion opens up a world in which there is such thing as a "good" and "bad" reason for an abortion." Pam Lowe, *Why I oppose a ban on sex-selection abortion*, THE CONVERSATION, Jan. 26, 2015, http://theconversation.com/why-i-oppose-a-ban-on-sex-selection-abortion-36684. "What could stop a state from banning abortions for reasons the majority regards as "trivial," such as wanting to complete one's education or be successful in a career?" Bonnie Steinbock, *Preventing Sex-Selective Abortions in America: A Solution in Search of a Problem*, THE HASTINGS CENTER, Apr. 4, 2017, https://www.thehastingscenter.org/preventing-sex-selective-abortions-america-solution-search-problem/.

Thus, faced with legislation prohibiting sex discrimination by means of sex-selective abortion, even civil rights activists condemn such legislation as a "burden on women obtaining abortions that they want for whatever reason." Kelly P. Kissell, *Arkansas considers banning 'sex-selection' abortions*, APNEWS.COM, Feb. 9, 2017, https://apnews.com/c4c4d2f92b634a8f8e9d311b4c385fa9 (quoting Rita Sklar, executive director of Arkansas ACLU). "Once again, the call for government intervention to prevent sex selective abortion conflicts with the preservation of reproductive rights." DANIEL GOODKIND, SEX-SELECTIVE ABORTION, REPRODUCTIVE RIGHTS AND THE GREATER LOCUS OF GENDER DISCRIMINATION IN FAMILY FORMATION: CAIRO'S UNRESOLVED QUESTIONS 16 (1997), *available at* https://www.psc.isr.umich.edu/pubs/pdf/rr97-383.pdf. "[E]ven the most

terrible reason for having an abortion holds more sway than the best imaginable reason for compelling a woman to carry to term." Sarah Ditum, *Why Women Have a Right to Sex-Selective Abortion*, THE GUARDIAN, Sep. 19, 2013, https://www.theguardian.com/commentisfree/2013/sep/19/sex-selective-abortion-womans-right.

Given public support for using reproductive technology to choose the gender of born children, as well as cultural defense of sex-selective abortion, and data from son-preferring ethnic groups, it is impossible to deny that abortions for the purpose of sex-selection are routinely being performed in the United States.

III. Abortion for the Purpose of Eliminating a Disabled Person is Commonplace in the United States.

A 2012 study of Down syndrome terminations in the United States demonstrates that prospective parents choose to terminate approximately 67% of fetuses diagnosed prenatally with Down syndrome. J.L. Natoli et al., *Prenatal diagnosis of Down syndrome: a systematic review of termination rates (1995-2011)*, 32 PRENATAL DIAGNOSIS 142 (2012), *available at* https://www.ncbi.nlm.nih.gov/pubmed/22418958. The number of births of people with Down syndrome in the United States is therefore 30% below natural rates. Gert de Graaf et al., *Estimates of the live births, natural losses, and elective terminations with Down syndrome in the United States*, 167A AM. J. MED. GENETICS 756 (2015).

These numbers do not rival the decimation in Down syndrome populations in places like Iceland, where only one or two babies are born with Down syndrome per year, or Denmark, where only four prenatally diagnosed Down syndrome babies were born in 2016. Jerome Lejeune Foundation, *All Danish babies with Down syndrome aborted but 4 in 2016*, Dec. 22, 2017, https://lejeunefoundation.org/denmark-down-syndrome-abortion/. However, the United States' termination rate is sufficient to raise concern, particularly given that Down syndrome is the most common and among the least debilitating of the disorders that can be diagnosed prenatally. Lindsay Abrams, *Prenatal Testing: Earlier and More Accurate Than Ever*, THE ATLANTIC, Nov. 5, 2012, *available at* http://www.theatlantic.com/health/archive/2012/11/prenatal-testing-earlier-and-more-accurate-than-ever/264472/2/. People with Down syndrome can live lives of ordinary length and function well enough to live independently and be employed. National Down Syndrome Society, *Down Syndrome Facts*, https://www.ndss.org/about-down-syndrome/down-syndrome-facts/ (last visited Nov. 13, 2018). Though less thoroughly documented, fetuses diagnosed with more debilitating disorders are undoubtedly aborted at higher rates even than 67%. *See*, *e.g.*, I.C. Lakovschek et al., *Natural outcome of trisomy 13, trisomy 18, and triploidy after prenatal diagnosis*, 155A AM. J. MED. GENETICS 2626 (2011) (studying a population of prenatally diagnosed fetuses with triploidy, trisomy 13, and trisomy 18, and finding that 78% of cases were terminated, so only 22% remained for a study of "natural outcomes").

Government has myriad legitimate interests in preventing the termination of disabled fetuses. Disability rights activists argue that aborting a fetus on the basis of disability is the vilest form of disability discrimination, victimizing the disabled "at their most vulnerable stage." Grazie Pozo Christie, *Eugenics and Equality Can't Mix: Aborting babies with detected disabilities is incompatible with equality*, U.S. NEWS & WORLD REPORT, Aug. 26, 2016, *available at* https://www.usnews.com/opinion/articles/2016-08-26/eugenic-abortion-is-a-challenge-to-equality-for-people-with-disabilities. In addition to moral concerns, a high rate of terminations raises practical concerns for the future diversity of the United States, because the practice of eliminating disabled people may become self-perpetuating: more terminations of disabled fetuses "could in turn result in increased social pressure to terminate, particularly if the diagnosed conditions were to become rarer in society resulting in a decline of support services (e.g. respite care homes for Down's [sic] Syndrome families). In practice, it could become increasingly difficult for a patient who has received a positive test result not to 'choose' to abort." CAROLINE WRIGHT, PHG FOUNDATION, CELL-FREE FETAL NUCLEIC ACIDS FOR NON-INVASIVE PRENATAL DIAGNOSIS: REPORT OF THE UK EXPERT WORKING GROUP 17 (2009), *available at* http://www.phgfoundation.org/documents/214_1260287360.pdf. Moreover, eliminating most people with disabilities raises grave concerns for the lives of those who do live with disabilities. In addition to dwindling support for their unique challenges, increasing rarity and the sense of

disability being "avoidable" is likely to increase the stigma associated with disability. *Id.* at 29.

IV. Eugenic Abortions are Likely to Become More Common in the U.S. As Non-Invasive Prenatal Diagnostic Tools are Increasingly Available and Increasingly Sophisticated.

Compounding the timeless objections to determining which humans will be born based on traits like sex and disability is the strong likelihood that the practice of trait-selective abortion is going to grow exponentially in frequency because of the widespread use of non-invasive prenatal diagnostic ("NIPD") technology. *See* Erin Biba, *This Simple Blood Test Reveals Birth Defects—And the Future of Pregnancy*, WIRED MAGAZINE, Dec. 24, 2012, https://www.wired.com/2012/12/ff-prenatal-testing/; Henry T. Greely, *Get Ready for the Flood of Fetal Gene Screening*, 469 NATURE 289, 289 (2011). In the past several years, new NIPD tests have become available, both through providers and over-the-counter, that indicate very early in pregnancy the various genetic features of babies, including sex and disability status. *See*, *e.g.*, Abrams, *supra*; Carolyn Y. Johnson, *DNA Blood Test Can Detect Prenatal Problems*, BOSTON GLOBE, Feb. 26, 2014, *available at* http://www.bostonglobe.com/lifestyle/health-wellness/2014/02/26/new-study-suggests-prenatal-genetic-tests-could-offered-all-pregnant-women/V1GQuRL4jkr1M6Oe1XcQCK/story.html.

The new tests, which evaluate fetal DNA present in the mother's blood, have three major advantages over past methods of prenatal testing: (1) they are non-invasive of the uterus because they require only a maternal blood test, (2) they are increasingly inexpensive as the technology becomes more widespread, and (3) they are accurate very early in pregnancy. Jaime S. King, *And Genetic Testing for All . . . The Coming Revolution in Non-Invasive Prenatal Genetic Testing*, 42 Rutgers L. J. 599, 616 (2011). As a result of all of these features, medical and social commentators agree that the incidence of trait-selective abortion is likely to greatly increase in the coming years. *See*, *e.g.*, Wright, *supra*, at 19 ("The major ethical concern in this area is therefore that prenatal fetal sex determination, in combination with termination of pregnancy, could result in sex selection for non-medical or 'trivial' reasons, which could have major implications for society."); Michael Stokes Paulsen, *It's a Girl*, PUBLIC DISCOURSE, Oct. 24, 2011, https://www.thepublicdiscourse.com/2011/10/4149/ ("Watch for a spike in abortion rates over the next few years as parents find it easier and cheaper to 'choose' to have a boy by killing the fetus if . . . it's a girl.").

V. Anti-Discrimination Laws Like HEA 1337 are a Reasonable Legislative Response to Odious Social Practices.

The Court should grant certiorari in order to vindicate states' rights to pass sensible legislation designed to address the troubling phenomenon of

discrimination based on race, gender, and disability in the abortion context. The State of Indiana undeniably has a legitimate interest in trying to end discrimination against racial minorities, the female sex, and disabled persons. There is ample evidence, from this country and others, to support the enactment of legislative prohibitions as one strategy for combating such invidious discrimination.

For example, although racial discrimination in medicine is a complicated issue that defies simple solution, the Institute of Medicine recommended enforcement of anti-discrimination laws as one strategy for addressing it. *See* IOM, *supra*, at 187-88. There is no reason to think that enforcing a prohibition on racial discrimination in the abortion industry would contribute any less to ameliorating the gross racial disparities in that setting.

Meanwhile, as noted above, many countries prohibit sex discrimination in the context of other reproductive technologies. *See supra* Section II.B. Some countries also prohibit sex-selective abortion,[3] while

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[3] *See*, *e.g.*, Chinadaily.com, *China bans selective abortion to fix imbalance*, July 16, 2004, http://www.chinadaily.com.cn/english/doc/2004-07/16/content_349051.htm; Arindam Nandi & Anil Deolalikar, *Does a legal ban on sex-selective abortions improve child sex ratios? Evidence from a policy change in India*, 103 J. OF DEVEL. ECON. 216 (2013) (arguing that India's ban on sex-selective abortions has had a positive impact on that country's gender imbalance), *available at* https://econpapers.repec.org/article/eeedeveco/v_3a103_3ay_3a2013_3ai_3ac_3ap_3a216-228.htm.

others are considering banning it.[4] And as Petitioners have pointed out, many other States have already enacted laws banning abortions on the basis of race, gender, or disability. *See* Pet. for Cert. at 25.[5]

Banning abortions on the basis of race, gender, and disability is a prudent—even laudable—step for a legislature seeking to deter increasingly widespread eugenic practices that devalue and disadvantage the most vulnerable members of society. This Court should not permit the Seventh Circuit decision invalidating such a ban to stand.

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[4] *See*, *e.g.*, Adam Forrest, *Early Gender tests 'leading to selective abortions of girls in UK'*, INDEPENDENT, Sept.17, 2018, https://www.independent.co.uk/news/health/selective-abortions-gender-tests-girls-uk-labour-a8540851.html (discussing a movement in the UK to ban sex-selective abortion).

[5] Eight state laws outlawing sex-selective abortion: Ariz. Rev. Stat. Ann. § 13-3603.02; Ark. Code Ann. § 20-16-1904 (eff. Jan. 1, 2018); Kan. Stat. Ann. § 65-6726; N.C. Gen. Stat. § 90-21.121; N.D. Cent. Code § 14-02.1-04.1; Okla. Stat. tit. 63, § 1-731.2; 18 Pa. Cons. Stat. § 3204; S.D. Codified Laws § 34-23A-64. One state law banning abortions on the basis of race: Ariz. Rev. Stat. Ann. § 13-3603.02. Three state laws banning abortions on the basis of genetic abnormality: La. Rev. Stat. Ann. § 40:1061.1.2; N.D. Cent. Code § 14-02.1-04.1; Ohio Rev. Code Ann. § 2919.10.

CONCLUSION

The Supreme Court should grant certiorari in this case in order to reverse the Seventh Circuit and affirm that States may prohibit abortion based on a baby's race, gender, or disability.

Respectfully submitted,

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