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

AMICI CURIAE BRIEF OF 547 DEANS, CHAIRS, SCHOLARS AND PUBLIC HEALTH PROFESSIONALS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE GUTTMACHER INSTITUTE, AND THE CENTER FOR U.S. POLICY, IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Table of Contents

Table of Contents

Page

TABLE OF APPENDICES

TABLE OF CITED AUTHORITIES

Page

Cases

Statutes & Rules

Other Authorities

Cited Authorities

Page

Cited Authorities

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

INTEREST OF *AMICI CURIAE* [1]

The 547 individual *Amici* are Deans, Chairs, Scholars, and Public Health Professionals appearing in their individual capacities. They include many of the Nation's leading academic scholars and research experts in public health, reproductive health, and health policies that affect the Nation's most vulnerable, at-risk populations. Their collective expertise focuses on low-income people, including women, children, and families who experience heightened health threats and systemic barriers to essential health care services, including to reproductive health care. *Amici* include many public health professionals who work directly with medically underserved communities and have front-line and first-hand experience with the risks and barriers these populations confront daily. The full list of individual *Amici Curiae* Deans, Chairs, Scholars, and Public Health Professionals is printed in an appendix to this brief.

The American Public Health Association ("APHA") is an organization of nearly 25,000 public health professionals and a nearly 150-year perspective that champions the health of all people and all communities, strengthens the profession of public health, shares research and information, promotes best practices, and advocates for public health issues and policies grounded in scientific research. APHA has long recognized that access to the full range of reproductive health services, including

1. Pursuant to Supreme Court Rule 37.6, *Amici* certify that no party or counsel for a party authored this brief in whole or in part, and no party other than *Amici* or their counsel contributed money intended to fund the preparation or submission of the brief. The parties respectively filed blanket written consent to the filing of *amicus curiae* briefs, in support of either party or neither party.

abortion, is a fundamental right integral to the health and well-being of individual women and to the broader public health. APHA opposes restrictions that (1) deny, delay, and impede access to abortion services, therefore increasing women's risk of injury or death, and (2) coerce women to carry unintended pregnancies to term.

The Guttmacher Institute is a leading research and policy organization committed to advancing sexual and reproductive health and rights worldwide. The Institute generates data and analysis to defend and advance people's ability to access the full range of sexual and reproductive health care—including safe, legal, and affordable abortion—with a particular focus on addressing historical and ongoing oppressions due to race, gender, sexuality, income, age, or immigration status. Guttmacher produces high quality data that inform evidence-based policies and demonstrate the harms caused by ideologically-motivated abortion restrictions and the clear violation of basic human rights such restrictions represent.

The Center for U.S. Policy ("CUSP") is a nonpartisan, not-for-profit research and education organization dedicated to enhancing the health, safety, and economic opportunity of all Americans. CUSP's work is premised on and promotes the values of freedom, responsibility, and compassion. CUSP's priorities include protecting the rights of health care providers to exercise their professional discretion in treating patients and opposing governmental interference in health care decision making.

SUMMARY OF THE ARGUMENT

I.

The ability to safely and legally terminate a pregnancy is both an individual constitutional right and a public health concern. Abortion is an essential component of reproductive health. Despite major advances in birth control, nearly half of women[2] who experience unintended pregnancies (including both mistimed and unwanted pregnancies) were attempting to prevent pregnancy with contraception. Compared to those that are planned, unintended—and particularly unwanted—pregnancies carry far greater health risks.

Any ban on pre-viability abortion—such as Mississippi's, which bans nearly all abortions greater than fifteen weeks into pregnancy and provides no exceptions for rape or incest—carries major public health implications because it forces women to carry pregnancies to term under adverse circumstances marked by substantially greater risks to their health and that of their families. Of particular concern to *Amici*, any ban will disproportionately affect young women, women of color, and low-income women who live in families and

2. Although this brief refers to women throughout, *Amici* recognize that the public health interest lies in protecting all people who may become pregnant; *Amici* accordingly underscore the major risks a ban would impose on people who, although born female, identify as non-binary or male. Indeed, the rate of sexual assault against transgender men is shockingly high. *See* NATL. CTR. FOR TRANSGENDER EQUALITY, *2015 US Transgender Survey Executive Summary* (2016) at 13, https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf.

communities already vulnerable to elevated health and social risks and reduced access to necessary health care.

II.

The public health risks of forcing women to carry unintended, and especially unwanted, pregnancies to term, wash over families. Elevated risks to life, health, and well-being include maternal mortality, prematurity, infant mortality, developmental difficulties, and increased likelihood of exposure to significant traumas, whose lifelong, adverse physical and mental health effects trigger intergenerational harm.

III.

A wealth of evidence demonstrates a central paradox: fourteen of the states with the nation's most restrictive abortion laws, including Mississippi, invest the least in policies and programs of proven importance and value to the health and well-being of women, children, and families. Mothers, infants, and children in these fourteen states also experience the worst health outcomes, as revealed by key indicators of maternal and child health. Indeed, one leading study of state-level population health ranks Mississippi last in the nation on a composite score consisting of measures that include infant mortality, preventable deaths, and children without age-appropriate medical and dental preventive health care visits in the past year.

ARGUMENT

Mississippi's unconstitutional pre-viability abortion ban threatens the public health in Mississippi and beyond.

Mississippi seeks to force women[3] to forgo a recognized and fundamental constitutional right to control their own health and to make for themselves and their families—in consultation with their chosen health professional—the most intimate and personal choices free from state interference. *Cf. Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 846–47 (1992). The near total ban Mississippi seeks to impose before viability contravenes settled constitutional law and disregards the significant burdens and multiple public health risks this ban creates. *Amici* urge this Court to affirm the Fifth Circuit's rejection of Mississippi's law as unconstitutional.

I. Abortion Is An Essential Component Of The Full Continuum Of Reproductive Health Care And A Basic Means Of Avoiding The Adverse Health Effects Of Unintended Pregnancy

Abortion access is an essential component of reproductive health care critical to public health. A core principle of public health is that maternal and child health are closely associated with women's ability to plan their pregnancies. *See* March of Dimes, *Planning Your Pregnancy* (2017), https://www.marchofdimes.org/pregnancy/ planning-your-pregnancy.aspx. Yet in 2011, forty-five percent of U.S. pregnancies (2.8 million out of 6.1 million) were unintended, meaning they were either mistimed—occurring when a woman did not, at that time, desire to be pregnant—or unwanted— occurring when a woman did not, at that time, or at any future point, desire to be pregnant. Guttmacher Institute, *Unintended Pregnancy in the United States* (2019), https://www.

3. *See* n.2, *supra* regarding *Amici's* use of the term "women."

guttmacher.org/fact-sheet/unintended-pregnancy-united-states; Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States 2008–2011*, 374 New Eng. J. Med. 843, 843 (2016), https://www.nejm.org/doi/full/10.1056/nejmsa1506575.

Forcing women to carry unintended, and especially unwanted, pregnancies to term negatively affects health. Without the option of abortion, women lose the ability to plan their lives and to maximize opportunities for better health for themselves and their families.

Steadily over the decades, the proportion of women seeking abortion has declined as availability and use of the most effective forms of contraception has risen. *See* Finer & Zolna, *supra*; Amy M. Branum & Jo Jones, *Trends in Long-Acting Reversible Contraception Use Among U.S. Women Aged 15–44*, 188 Natl. Ctr. for Health Stat. Data Brief (2015), https://pubmed.ncbi.nlm.nih.gov/25714042/; *see also* Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14, 17 (2017), https://doi.org/10.1016/j.contraception.2017.10.003.[4] Still, fifty-one percent of women who terminated their pregnancies

4. Poor women and women of color have less access to the most effective family planning methods. Leah Henke et al., *Barriers to Obtaining Long-Acting Reversible Contraception Among Low-Income Women*, 135 Ob. & Gyn. 94S (2020), https://doi.org/10.1097/01.aog.0000664132.19131.2f; Kywanna Alfred & Katherine M. Holmes, *The Intersection of Race and Class and the Use of Long Acting Reversible Contraception (LARC) a Quantitative Analysis*, 133 Ob. & Gyn. 10S (2019), https://doi.org/10.1097/01.aog.0000559350.66295.a3.

had used contraceptives during the month in which they conceived. Rachel K. Jones, *Reported Contraceptive Use in the Month of Becoming Pregnant Among U.S. Abortion Patients in 2000 and 2019*, 97 CONTRACEPTION 309, 310 (2018), https://www.guttmacher.org/article/2018/01/reported-contraceptive-use-month-becoming-pregnant-among-us-abortion-patients-2000. For this and other reasons, safe, legal abortion is a vital component of the reproductive health continuum.

Poverty, youth, and minority racial status, each standing alone, increases the risk of unintended pregnancy. GUTTMACHER INSTITUTE, *Unintended Pregnancy in the United States*, *supra*. Low-income women, *i.e.* those with incomes below 200 percent of the federal poverty level ("FPL"),[5] experience unintended pregnancy rates significantly higher than those who are not low-income; among women living below FPL, the unintended pregnancy rate is five times higher than that experienced by higher-income women. Finer & Zolna, *supra*, at 846. The racial demography of poverty in the United States means that low-income women are also disproportionately women of color. Women who fall into one or more of these often-overlapping categories are uniquely vulnerable to deep poverty, health risk exposure, and health care exclusion and discrimination. *See generally*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *Minority Health: Recent Findings* (2013), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/

5. The federal poverty level in the 48 contiguous states and the District of Columbia stands at $12,880 in 2021 for individuals and at $17,420 for a family of 2. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., *Annual Update of the HHS Poverty Guidelines*, 86 Fed. Reg. 7733 (Feb. 1, 2021).

minority/minorfind/minorfind.pdf. These women and their families would bear the brunt of an abortion ban.

Women recognize the vital importance of planned pregnancy. Those who seek pre-viability[6] abortion overwhelmingly do so because they decide that abortion is the best choice for their health and well-being and that of their families, including children already in their care. *See* Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 112 (2005), https://www.guttmacher.org/journals/psrh/2005/reasons-us-women-have-abortions-quantitative-and-qualitative-perspectives; *see also* Maggie Kirkman et al., *Reasons Women Give for Abortion: A Review of the Literature*, 12 ARCHIVES OF WOMEN'S MENTAL HEALTH 365 (2009), https://pubmed.ncbi.nlm.nih.gov/19517213/; M. Antonia Biggs, Heather Gould & Diana Greene Foster, *Understanding why women seek abortions in the U.S.*, 13 BMC WOMEN'S HEALTH 7 (2013) https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-13-29) (finding nearly thirty percent of women cite needing to care for other children as a primary reason for seeking abortion).

Unintended, and especially unwanted, pregnancies carry major short- and long-term health risks. The fallout from preventing women from terminating unintended pregnancies washes over women and their families, including the children they already have; indeed, nearly sixty percent of women seeking abortion already have

6. Pre-viability abortion is generally understood to mean termination of pregnancy at a point at which survival outside the uterus is impossible or extremely unlikely.

children. Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008,* Guttmacher Institute (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014. Conversely, the ability to plan a pregnancy allows women to optimize their own health outcomes and those of their families.

A. Abortion Plays an Essential Role in Women's Health

Abortion, especially pre-viability, is among the safest medical procedures. *See* Natl. Acad. of Sciences, Engineering & Medicine, *The Safety and Quality of Abortion Care in the United States* (2018), https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states. Legal abortion is markedly safer than childbirth: nationally, health risks associated with childbirth are fourteen times greater than risks associated with abortion. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Ob. & Gyn. 215, 216 (2012), https://pubmed.ncbi.nlm.nih.gov/22270271/; *accord Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315, *as revised* (June 27, 2016); *see also* Centers for Disease Control & Prevention, *Abortion Surveillance* (2018), https://perma.cc/X2KW-MDSA (reporting 0.44 deaths per 100,000 legally induced abortions in the United States from 2013–2017). Particularly of note, risks are substantially greater in Mississippi, where it is approximately seventy-five times more dangerous for women to carry a pregnancy to term than to have an abortion. *See* Mississippi Dept. of Health, *Miss. Maternal Mortality Report 2013–2016* 5,

25 (2021), https://perma.cc/H362-RN2Q (reporting 33.2 pregnancy-related deaths per 100,000 live births).

Births involving unintended pregnancies are associated with a host of adverse health and social outcomes for women, and ultimately, their families. Women who carry unintended, and especially unwanted, pregnancies to term are more likely to experience a wide range of adverse health outcomes including depression, poor birth outcomes, interpersonal violence, and psychological distress. Compared to those able to obtain abortions, women who are denied abortions are also subsequently more likely to live in poverty, more likely to lack financial supports critical to better health outcomes, such as housing and nutrition, and more likely to raise their children alone. *See* Diana Cheng et al., *Unintended Pregnancy and Associated Maternal Preconception, Prenatal and Postpartum Behaviors*, 79 Contraception 194, 195 (2009), https://pubmed.ncbi.nlm.nih.gov/19185672/; Mary M. Goodwin et al., *Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996–1997*, 4 Maternal & Child Health J. 85–92 (2000), https://pubmed.ncbi.nlm.nih.gov/10994576/; Caitlin Gerdts et al., *Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy*, 26 Women's Health Issues 55–59 (2015), https://pubmed.ncbi.nlm.nih.gov/26576470/; Sara Roberts et al., *Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion*, 12 BMC Med. 144 (2014), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z; Katherine Barton et al., *Unplanned pregnancy and subsequent psychological distress in partnered women:*

a cross-sectional study of the role of relationship quality and wider social support, 17 BMC Pregnancy Childbirth 44 (2017), https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1223-x; Diana Green Foster et al., *Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, 108 Am. J. Pub. Health 407–13 (2018), https://doi.org/10.2105/ajph.2017.304247.

Conversely, the ability to plan pregnancy and childbirth is positively associated with health and well-being. Women able to obtain an abortion they seek are subsequently more likely to have and achieve an aspirational life plan compared to women who sought abortion but were turned away. Ushma D. Upadhyay, M. Antonia Biggs & Diana Greene Foster, *The effect of abortion on having and achieving aspirational one-year plans*, 15 BMC Women's Health 6 (2015), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1. They are also significantly more likely to complete a postsecondary degree. Lauren J. Ralph et al., *A Prospective Cohort Study of the Effect of Receiving versus Being Denied an Abortion on Educational Attainment,* 29 Women's Health Issues 459 (2019), https://doi.org/10.1016/j.whi.2019.09.004; https://pubmed.ncbi.nlm.nih.gov/31708341/.

Such women also report lower stress levels and better financial well-being in the years after obtaining an abortion. Laura F. Harris et al., *Perceived stress and emotional social support among women who are denied or receive abortions in the United States: a prospective cohort study*, 14 BMC Women's Health 1–11 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4080695/; Sarah

Miller, Laura R. Wherry & Diana Greene Foster, *The Economic Consequences of Being Denied an Abortion,* Natl. B. Econ. Research (2020) at 3, https://www.nber.org/system/files/working_papers/w26662/w26662.pdf (abortion denial increases amount of debt thirty days or more past due by seventy-eight percent and increases negative public records, such as bankruptcies and evictions, by eighty-one percent); *see also* Diana Greene Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172 JAMA Pediatrics 1053, 1058 (2018), https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454 (finding women denied abortions significantly less likely to be employed full time, with no analytic group differences in receipt of public assistance).

B. Abortion Access is Related to Healthy Pregnancy and Childbirth

Several important influences on maternal and child health flow from ensuring that women are able to plan a birth. First, planning a birth means being able to enter pregnancy in the best health possible. *See* Centers for Disease Control & Prevention (hereinafter "CDC"), *Planning for Pregnancy* (2020), https://www.cdc.gov/preconception/planning.html (noting pre-conception care optimizes overall health and allows for physical and behavioral risk mitigation). Where pregnancy is unintended, women lack early opportunities to make lifestyle changes before becoming pregnant and giving birth. Women who experience an unintended pregnancy may have lived their lives in all the normal ways people do when pregnancy is not planned. They may drink alcohol,

smoke, or manage a health condition with medication that is contraindicated in pregnancy. *See* Kay Johnson et al., *Preconception Care to Improve Pregnancy Outcomes: Clinical Practice Guidelines*, 55 MORBIDITY & MORTALITY WKLY. REV. 1–23 (2006), https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm; Kathleen Green-Raleigh et al., *Pregnancy planning status and health behaviors among nonpregnant women in a California managed health care organization*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 179, 181 (2005), https://www.guttmacher.org/journals/psrh/2005/pregnancy-planning-status-and-health-behaviors-among-nonpregnant-women; *see also* Lisbet S. Lundsberg, Meredith J. Pensak & Aileen M. Gariepy, *Is Periconceptional Substance Use Associated with Unintended Pregnancy?,* 1 WOMEN'S HEALTH REP. 17, 19–20 (2020), https://www.liebertpub.com/doi/10.1089/whr.2019.0006; Ted Joyce, Robert Kaestner & Sanders Korenman, *The Stability of Pregnancy Intentions and Pregnancy-Related Maternal Behaviors*, 4 MATERNAL & CHILD HEALTH J. 171–78 (2020), https://www.researchgate.net/publication/12229447_The_Stability_of_Pregnancy_Intentions_and_Pregnancy-Related_Maternal_Behaviors; Cheng et al., *Unintended Pregnancy, supra.*

Second, when pregnancy is planned, comprehensive prenatal care—access to which is a major determinant of women's and infants' health— is especially likely to begin early. CDC, *Timing and Adequacy of Prenatal Care in the United States*, 2016 (2018), https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_03.pdf. Women with unintended, and particularly unwanted, pregnancies are far less likely to receive adequate and timely prenatal care, which subsequently places them and

their infants at greater risk for poor health outcomes. *See* Kathryn Kost, David J. Landry & Jacqueline E. Darroch, *The Effects of Pregnancy Planning Status on Birth Outcomes and Infant Care*, 30 Persp. On Sexual & Reprod. Health 223, 223 (1998), https://pubmed.ncbi.nlm.nih.gov/9782045/ (noting women with unintended pregnancies less likely to recognize pregnancies within first six weeks of conception and significantly less likely than those who planned pregnancies to receive care in first eight weeks). Extensive research documents the link between unintended pregnancy and late entry into prenatal care, inadequate prenatal care, and poor maternal and infant health outcomes. *See generally*, Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (1995), https://doi.org/10.17226/4903. Indeed, nearly all peer-reviewed studies find a strong relationship between unintended pregnancy and late entry into prenatal care, and an even stronger relationship among women with unwanted pregnancies. *Id.* at 66; *see also* Cheng et al., *Unintended Pregnancy, supra* at 196 (finding mothers with unwanted pregnancies less likely to receive prenatal care during the first trimester, compared to women with intended pregnancies); Kathryn Kost & Laura Lindberg, *Pregnancy Intentions, Maternal Behaviors, and Infant Health: Investigating Relationships with New Measures and Propensity Score Analysis*, 52 Demography 83, 89 (2015), https://link.springer.com/article/10.1007/s13524-014-0359-9 (assessing U.S. National Survey of Family Growth 2015 data and finding fewer unwanted births received early prenatal care, as compared to wanted births).

The imperative of abortion access to maternal health takes on added urgency where maternal mortality is concerned. Unintended pregnancy carries an increased risk of maternal death. Amirhossein Moaddab et al., *Health Care Disparity and Pregnancy-Related Mortality in the United States, 2005–2014*, 131 Ob. & Gyn. 707, 709–10 (2018), https://journals.lww.com/greenjournal/Fulltext/2018/04000/Health_Care_Disparity_and_Pregnancy_Related.15.aspx?sessionEnd=true. This risk is compounded for women of color: pregnancy-related mortality rates for black women are over three times higher than for white women; rates for Native American and Alaska Native women are over two times higher compared to rates for white women. Samantha Artiga et al., *Racial Disparities in Maternal and Infant Health: An Overview*, Kaiser Family Foundation (2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/.

Restrictive abortion policies are likewise linked to maternal death. States whose composite abortion restriction scores (an 8-factor test developed by researchers) were the highest also showed a seven percent increase in total maternal mortality. Dovile Vilda et al., *State Abortion Policies and Maternal Death in the United States, 2015–2018*, Am. J. Pub. Health e1, e5 (2021), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2021.306396 (examining maternal mortality in context of current abortion regulations). Put simply, women living in states with the most restrictive abortion policies—and thus the least abortion access—were found to be more likely to die while pregnant or shortly thereafter than women living in states with less restrictive abortion policies,

regardless of state-to-state differences in poverty, race/ethnicity, and education. *Id.*

II. Children Of Women Who Experience Unintended Pregnancies Face Greater Risks To Life And Health, Including Pre-Term Birth, Low Birthweight, And Impaired Child Development And Well-Being

Unintended pregnancies resulting in a live birth entail higher risks to children's life and health than planned pregnancies, underscoring the individual and public health importance of planned pregnancy and birth. These risks include pre-term births, low birthweight, and impaired development and well-being.

A. Unintended Pregnancy is More Likely to Result in Pre-Term Birth, Low Birthweight, and Impaired Development

Unintended, and especially unwanted, pregnancy is strongly associated with preterm birth and low birthweight, linked outcomes[7] that together are leading causes of child health problems and infant mortality. *See* Prakesh S. Shah et al., *Intention to Become Pregnant and Low Birth Weight and Preterm Birth: A Systematic Review*, 15 Maternal & Child Health J. 205, 209 (2011), https://pubmed.ncbi.nlm.nih.gov/20012348/ (finding significantly greater odds of prematurity associated with unintended

7. The highest contributing factor for low birthweight is preterm birth. Committee on Understanding Premature Birth & Assuring Healthy Outcomes, *Preterm Birth: Causes, Consequences, and Prevention* 120–21 (Richard E. Behrman & Adrienne Stith Butler eds., 2007).

pregnancies); INSTITUTE OF MEDICINE, *Preventing Low Birthweight* (1985), https://www.ncbi.nlm.nih.gov/books/NBK214468/ (finding most infant deaths a consequence of low birthweight). Regardless of age, race, education, and income, unwanted pregnancy is significantly more likely to result in pre-term birth and low birthweight. Kost & Lindberg, *supra*, at 100–01; Jennifer A. Hall et al., *Pregnancy Intention and Pregnancy Outcome: Systematic Review and Meta-Analysis*, 21 MATERNAL & CHILD HEALTH J. 670, 678 (2017), https://link.springer.com/article/10.1007/s10995-016-2237-0.

Preterm birth and low birthweight can cause lifelong health and developmental challenges. Babies born too early (especially before thirty-two weeks) have higher rates of death, chronic illness, and developmental disability than their later-born counterparts, and are more likely to experience breathing problems, chronic lung disease, cardiovascular disorders, feeding difficulties, intestinal injury, cerebral palsy, intellectual and developmental disabilities, vision problems, hearing problems, and a compromised immune system. *See* CDC, *Preterm Birth* (2020), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm; MARCH OF DIMES, *Long-Term Health Effects of Premature Birth* (2019), https://www.marchofdimes.org/complications/long-term-health-effects-of-premature-birth.aspx; *see generally* COMMITTEE ON UNDERSTANDING PREMATURE BIRTH, *supra* n.7, at ch. 10. Low birthweight increases children's risk for neurodevelopmental issues and congenital anomalies and elevates lifelong health risks. *See generally* INSTITUTE OF MEDICINE, *Preventing Low Birthweight, supra*. Inadequate prenatal care, also linked to unintended pregnancy, increases these risks.

Hall et al., *supra,* at 700. Moreover, children born from unplanned pregnancies—either mistimed or unwanted—are more likely to exhibit higher levels of fearfulness, less opportunity for skill development, and lower levels of positive affect before two years of age. *See* Institute of Medicine, *The Best Intentions*, *supra*, at 72–74; Nazli Baydar, *Consequences for Children of Their Birth Planning Status*, 27 Family Planning Persp. 228–45 (1995), https://www.jstor.org/stable/2136174.

Births from unwanted pregnancies also negatively impact the development of earlier-born children. From six months to four-and-a-half years after their mothers sought but were unable to obtain abortions, earlier-born children of women denied abortions had lower mean child development scores than children of women who received a wanted abortion. *See* Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics 183, 185 (2019), https://www.jpeds.com/action/showPdf?pii=S0022-3476%2818%2931297-6.

B. Children of Women Who Experience Unintended Pregnancies Are More Likely to Suffer Adverse Child Experiences With Lifelong Consequences

Children born of unintended pregnancies, and their siblings, are more likely to be exposed to adverse child experiences ("ACEs"), *i.e.* "potentially traumatic events that occur in childhood (0–17 years)." CDC, *Preventing Adverse Childhood Experiences* (2021), https://www.cdc.gov/violenceprevention/aces/fastfact.html. ACEs range from a child's experience of parental separation

to violence, abuse, neglect,[8] and other traumas. *See* Data Resource Ctr. for Child & Adolescent Health, *2018–2019 National Survey of Children's Health* (2021) (data query: Indicator 6.13, *Has this Child Experienced One or More Adverse Childhood Experiences from the List of 9 ACEs?),* https://www.childhealthdata.org/browse/survey/results?q=4783&r=1&g=606.[9] ACEs cause toxic stress with potentially serious physical and mental health consequences that accompany children into

8. A child from a family with two unplanned births is 2.8 times more likely to have been abused than is a child from a family with no unplanned births; one from a family with three unplanned births is 4.6 times more likely to have been abused. Susan J. Zuravin, *Unplanned Childbearing and Family Size: Their Relationship to Child Neglect and Abuse*, 23 Family Planning Persp. 155, 159 (1991), https://www.jstor.org/stable/2135738; *see also* Institute of Medicine, *The Best Intentions*, *supra*; *see also* Baydar, *supra*, at 232; Kai Guterman, *Unintended Pregnancy as a Predictor of Child Maltreatment*, 48 Child Abuse & Neglect 160, 167 (2015), https://www.sciencedirect.com/science/article/abs/pii/S0145213415001945?casa_token=vb-9lm5FPJ8AAAAA:ncCXeNO6WTPPsQbSwKBBYcDkOVHKkE34H1I5dcUI4f9-26GQIpeb0C3nKBSE5TTCvmtJybfH (finding unintended pregnancy associated with psychological aggression and neglect, as well as significantly less positive relationships between mothers and their preschool children).

9. The ACEs recognized in the foundational survey are: (1) it has "somewhat often" or "very often" been very hard to cover basics (like food or housing) on the family's income; (2) a parent or guardian was divorced or separated; (3) a parent or guardian died; (4) a parent or guardian served time in jail; (5) the child saw or heard parents or adults slap, hit, kick, or punch one another in the home; (6) the child was a victim of violence or witnessed neighborhood violence; (7) the child lived with someone who was mentally ill, suicidal, or severely depressed; (8) the child lived with someone who had a problem with alcohol or drugs; (9) the child was treated or judged unfairly due to race/ethnicity.

adulthood. CDC, *Adverse Childhood Experiences* (2020), https://www.cdc.gov/violenceprevention/aces/index.html (ACEs "have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity").

1. Unintended Pregnancy Resulting in Birth is Associated with Violence Against Women and Lifelong Consequences for Children

Unintended pregnancy carries higher risks of domestic violence. David M. Fergusson et al., *Factors Associated with Reports of Wife Assault in New Zealand*, 48 J. Marriage & Fam. 407, 411–12 (1986), https://www.jstor.org/stable/352408 (finding, within six years following birth, women whose pregnancies were unintended experienced a 13.4 percent rate of physical violence, nearly three times the 5.4 percent rate for women whose pregnancies were planned); Julie A. Gazmararian et al., *The Relationship Between Pregnancy Intendedness and Physical Violence in Mothers of Newborns*, 85 Ob. & Gyn. 1031, 1033–35 (1995), https://pubmed.ncbi.nlm.nih.gov/7770250/ (finding higher rates of physical violence against women with unintended pregnancies, based on four-state study of data gathered from women three to six months after delivery). Between 5.6 and 10.7 percent of women whose pregnancies were unintended reported physical abuse; the rate for women who had planned their pregnancies was between 3.8 and 6.9 percent. Gazmararian et al., *supra.*

Domestic violence is toxic and traumatizing for children. CDC, *Preventing Adverse Childhood Experiences*, *supra*. Children of women who experience domestic violence

have increased risks of emotional, physical, and sexual abuse, of developing emotional and behavioral problems, and of increased exposure to other adversities. *See generally*, Stephanie Holt et al., *The Impact Of Exposure To Domestic Violence On Children And Young People: A Review Of The Literature*, 32 Child Abuse & Neglect 797 (2008), https://doi.org/10.1016/j.chiabu.2008.02.004.[10]

2. Unintended Pregnancy and Birth is Associated with Greater Parental Mental Health Challenges and Lifelong Consequences for Children

The mental health of parents is critical to the health of their children. Compared to women with planned pregnancies, mothers experiencing unintended pregnancy and birth were more likely to report postpartum depression, as well as poorer mental health later in life. Cheng et al., *supra*, at 196–97; Institute of Medicine, *The Best Intentions*, *supra*, at 75; Pamela Herd et al., *The Implications of Unintended Pregnancies for Mental Health in Later Life*, 106 Am. J. Pub. Health 421, 422 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4815713/pdf/AJPH.2015.302973.pdf; Jessica Houston Su, *Pregnancy Intentions and Parents' Psychological Well-Being*, 74 J. Marriage & Fam. 1182, 1190–93 (2012), https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1741-3737.2012.01006.x. Maternal depression limits the ability to nurture and is associated with long-term social-emotional, mental health, and behavioral problems in children. Sarah K.G. Jensen & Theresa S. Betancourt,

10. *See also* Guterman, *supra* n.8, at 167 (finding association between unintended pregnancies and fathers' physical aggression).

Recognizing the Complexity of Psychosocial Factors Associated With Children's Development—The Case of Maternal Depression, 4 JAMA Network Open 1 (2021), doi:10.1001/jamanetworkopen.2021.22310. A childhood marked by a parent's mental health struggles is linked to increased risk of mental illness, behavioral difficulties, and substance use in adulthood. CDC, *Preventing Adverse Childhood Experiences*, *supra*.

Overall, denying women the ability to plan their pregnancies negatively impacts their children, who are more likely to live in poverty and have a parent in emotional distress as result of the denial of the abortion. *See* Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term, supra*; Foster et al., *Comparison of Health, Development, supra*, at 1054.

3. Unintended Pregnancy and Birth is Associated with Elevated Rates of Death, Divorce, or Separation and Lifelong Consequences for Children

The loss of a parent or guardian through death, divorce, or separation is an ACE with potentially lifelong negative consequences for children. As noted *supra*, women with unintended pregnancies are at a higher risk for maternal death than women able to plan their pregnancies and birth. Moaddab et al., *supra*, at 709–10. Additionally, marriages that follow an unintended pregnancy have a higher chance of failure, regardless of whether the marriage is a first, second, or subsequent marriage. Institute of Medicine, *The Best Intentions, supra*, at 74.

III. Mississippi And Thirteen Other States With Extensive Abortion Restrictions Invest The Least In The Health And Well-Being Of Women And Children And Show The Worst Health Outcomes For Mothers, Infants And Children

A state-by-state[11] review of abortion restrictions, objective and widely-accepted measures of women's and children's health outcomes, and state investments in maternal and child health underscores a central paradox: among the fifty states and the District of Columbia, (1) Mississippi and other states with the most restrictive abortion policies invest the least in the well-being of women, children, and families; and (2) mothers, infants, and children in these high-restriction, low-investment states have the worst health outcomes. *See* App. Table 1 (ranking states from one to fifty-one on five distinct maternal and child health indicators, where ranking first for a particular measure indicates the state's outcomes for that measure are better than all other states); Table 2 (indicating the extent of each state's policies related to nine basic investments in maternal and child health programs); Table 3 (ranking fourteen states imposing seven or more abortion restrictions, including a gestational ban, in terms of their performance on five maternal and child health outcomes in Table 1); and Table 4 (ranking fourteen states imposing seven or more abortion restrictions, including a gestational ban, on their policies related to nine basic investments in maternal and child health programs).

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11. For purposes of this review, the District of Columbia was treated as a state, resulting in data and findings pertaining to 51 "states."

Further, the unintended pregnancy rate is highest among the states with the most restrictive abortion policies. Eleven out of the fourteen high-restriction states whose results appear on Tables 3 and 4 report unintended pregnancy rates at or above the U.S. average. *See* App. Tables 3, 4; *see generally* Kathryn Kost, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, Guttmacher Institute (2015), https://www.guttmacher.org/sites/default/files/report_pdf/stateup10.pdf.[12] Among all states tracking and reporting relevant data, Mississippi had the lowest rate of planned pregnancy (thirty-five percent). *Kost*, *Unintended Pregnancy Rates*, *supra*, at 7, 8, Table 1; *see also* United Health Foundation, *America's Health Rankings: Unintended Pregnancy* (2021), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/U.S (ranking Mississippi, based on 2018 CDC data, as the least healthy state in terms of the percentage of women with a recent live birth who experienced unwanted or mistimed pregnancies).

Taken together, the evidence overwhelmingly shows that compelling women to carry unintended—and especially unwanted—pregnancies to term is detrimental to the health of women, children, and families. The evidence also shows that Mississippi and other states with the Nation's most restrictive abortion policies simultaneously fail to invest in the very women, children, and families most heavily affected by unintended pregnancies.

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12. Not all states report unintended pregnancies. Among the fourteen high-restriction states, two do not report figures and one has a rate below the national average. *Id.*

A. Certain States, Including Mississippi, Lead the Nation in the Number of Abortion Restrictions

According to the Kaiser Family Foundation and the Guttmacher Institute, among the fifty states and the District of Columbia, Mississippi and thirteen other states impose the most restrictive abortion policies as measured by: (1) counseling requirements; (2) waiting periods; (3) ultrasound requirements; (4) parental notification and consent requirements; (5) gestational limits; (6) restrictions on insurance coverage for abortion; and (7) regulation of facilities and clinicians providing abortions.[13] *See* App. Tables 3, 4. Although many of these restrictions are common across states, only fourteen states have simultaneously pursued all seven categories of limitations. In addition to Mississippi, they are: Alabama, Arkansas, Indiana, Kansas, Kentucky, Louisiana, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, and Texas. *Id.*

The seven restrictions in Mississippi and thirteen other high-restriction states create obstacles to care that simply do not exist for other medical procedures that, like abortion, are safe and common. *Cf. Whole Woman's Health,* 136 S. Ct. at 2315 (noting mortality rate for colonoscopies ten times higher than that for abortion, liposuction twenty-eight times higher); *June Medical Services, LLC v. Russo*, 140 S. Ct. 2103, 2124 (2020). These restrictions reflect an ideologically-driven strategy to make abortion access practically and

13. Restrictiveness rankings are based on Kaiser Family Foundation data focused on state-level policies. KAISER FAMILY FOUNDATION, *State Health Facts, Women's Health: Women's Health Indicators: Abortion Statistics and Policies* (2021), https://www.kff.org/state-category/womens-health/abortion-statistics-and-policies/.

financially burdensome, if not impossible, regardless of the detrimental impact to public health. For example, gestational age bans, like Mississippi's, effectively preclude abortion entirely within a state's borders, while mandatory waiting periods trigger costly and time-consuming travel obligations, restrictions on health care providers and practice settings limit available providers, and restrictions on insurance coverage—including for Medicaid beneficiaries—increase out-of-pocket costs, often prohibitively. Ideologically-driven and medically unsupported efforts to hinder women's access to comprehensive reproductive healthcare also increasingly include restrictions on the use of medication abortions—accomplished through the FDA-approved use of the drugs mifepristone and misoprostol—as they become more common. Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, 49 Persp. on Sexual & Reprod. Health 17, 18 (2017), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.[14]

B. Measures of Health and Health Investment in Mississippi and Other High-Restriction States Reveal Deeply Deficient Safety Net Investments and Poor Health Outcomes Among Women, Children, and Families

Objective measures of public health and health investment reveal that Mississippi and its companion high-restriction states stand at the bottom of all states in terms of basic investment in maternal and child health programs and services, underscoring the disregard for public health inherent in its abortion ban.

14. Data related to restrictions on medication abortions is not currently adequately comprehensive for inclusion in the analysis undertaken herein.

Population health and health investment measures utilized in public health policy and practice fall into two categories: public health indicators and safety-net measures. These measures are considered leading methods for assessing health risks among women, mothers, infants, and children, as well as the strength of social and health investment. *See generally*, Russell S. Kirby & Sarah Verbiest, *Kotch's Maternal and Child Health: Programs, Problems and Policy in Public Health* (4th ed. 2021).

Widely accepted public health indicators regarding pregnancy, childbirth, deaths in infancy, and the well-being of children include: early entry into prenatal care, (care in the first trimester of pregnancy); infant mortality (infant death occurring before the first birthday); low birthweight (weight at birth of less than 5.5 pounds); poverty rate among children under five (children who live in families with incomes below FPL); and adverse childhood experiences, (defined in *supra* section II(B)). CDC, *Entry into Prenatal Care—United States, 1989–1997* (2000) at 393–98, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm; CDC, *Infant Mortality* (2021), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm; Natl. Cancer Institute, Natl. Institutes of Health, *Dictionary of Cancer Terms* (2021), https://www.cancer.gov/publications/dictionaries/cancer-terms/def/low-birth-weight; U.S. Dept. of Health & Human Servs., *Annual Update of the HHS Poverty Guidelines*, *supra* n.5.

Health safety-net measures consist of policies that extend health, health care, nutritional, and basic support services to the most vulnerable women, children, and

families. Noteworthy policies promote access to preconception and early and comprehensive perinatal health care, as well as offer nutritional support during pregnancy, infancy, and early childhood, and financial support for families with infants and young children. *See generally* Select Panel for the Promotion of Child Health, *Better Health for Our Children: A National Strategy, Report to the United States Congress and the Secretary of Health & Human Servs.* (1981), https://catalog.hathitrust.org/Record/000200804 (discussing health investments in children); *see also* CDC, *Health, United States* 6–7, 11–13 (2019), https://www.cdc.gov/nchs/hus/index.htm (discussing national and state-level women's health and well-being measures before and during pregnancy, and measures for infants and children).

Government safety net investment is commonly analyzed with reference to state Medicaid coverage policies for children and working-age adults;[15] financial assistance during pregnancy, infancy and childhood under states' Temporary Assistance for Needy Families (TANF)

15. Medicaid and its supplemental companion, the Children's Health Insurance Program ("CHIP"), codified respectively at 42 U.S.C. §§ 1396a *et seq. and* 1397 *et seq.*, insured 81.7 million adults and children as of March 2021. *See* Bradley Corallo & Robin Rudowitz, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment*, Kaiser Family Foundation (2021), https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/; *see also* Julia Paradise, Barbara Lyons & Diane Rowland, *Medicaid at 50*, Kaiser Family Foundation (2015), https://www.kff.org/report-section/medicaid-at-50-low-income-pregnant-women-children-and-families-and-childless-adults/ (Medicaid insures forty-six percent of all U.S. births and covers seventy-seven percent of children in poverty under eighteen).

programs;[16] and assistance furnished to women, infants and young children under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[17] These basic supports take on special importance for women who experience unintended pregnancy who, as noted *supra*, are collectively more likely to be young, poor, financially and socially disadvantaged, and disproportionately women and children of color who labor under added historical burdens of racial segregation, discrimination, and exclusion.

1. Maternal and Child Health Indicators in Mississippi and the Other High-Restriction States Reveal Poorer Public Health Outcomes Compared to States with Greater Abortion Access

The fourteen high-restriction states show consistently poor performance on maternal and child health indicators. Among the fourteen states with the highest number of

16. Federal TANF grants to states extend basic financial assistance and supportive services to families with children. 42 U.S.C. § 601 *et seq.* State TANF spending and the level of assistance families receive is discretionary. *See, e.g.*, Center on Budget & Policy Priorities, *Policy Basics: Temporary Assistance for Needy Families* (2021), https://www.cbpp.org/research/family-income-support/temporary-assistance-for-needy-families.

17. Federal WIC grants to states cover supplemental foods, nutrition education, and health care referrals for low-income pregnant, breast-feeding, and postpartum women, as well as at-risk infants and children. WIC serves fifty-three percent of all infants born in the U.S. Food and Nutrition Service, U.S. Dept. of Agriculture (hereinafter "FNS"),*WIC at a Glance* (2013), https://www.fns.usda.gov/wic/about-wic-glance.

abortion restrictions, nine (64.3 percent) rank in the lower half of states in terms of early entry into prenatal care; ten (71.4 percent) rank in the lower half of all states in terms of infant mortality; and eight (57.1 percent) rank in the lower half of states in terms of low birthweight. With respect to young children in poverty, ten of the fourteen states (71.4 percent) show childhood poverty rates higher than twenty-five other states, two—Louisiana and Mississippi—rank 50th and 51st respectively. Considering ACEs, eleven of fourteen states rank in the lower half of all states (78.6 percent) in terms of the number of at-risk children. *See* App. Table 3.

Even as Mississippi seeks to ban abortion pre-viability, its residents experience some of the nation's most elevated reproductive health risks. Further, Mississippi's health care system is grievously unprepared to deal with the cascading effects of unintended pregnancy. Mississippi ranked last in the Commonwealth Fund's 2020 Composite Score for Health System Performance in the United States, including ranking as worst performing for, among other measures: infant mortality; mortality amenable to health care or preventable deaths; and children without age-appropriate medical and dental preventive care visits in the past year. COMMONWEALTH FUND, *2020 Scorecard on State Health System Performance, Mississippi* (2020), https://2020scorecard.commonwealthfund.org/files/Mississippi.pdf.

2. Safety Net Investment is Inadequate in Mississippi and the Other High-Restriction States and Lower than that in States with Greater Abortion Access

States with the greatest number of abortion restrictions—including a gestational ban on abortion like Mississippi's— show the lowest overall investment rates in women, children, and families, even when it comes to medical care itself. This lack of investment puts the lie to abortion bans justified by a claimed interest in the well-being of women, children, and families.

The most restrictive abortion states include half of the twelve states that have not adopted the Medicaid program expansion authorized in the Patient Protection and Affordable Care Act ("ACA"), Pub. L. 111–48 (Mar. 23, 2010). Medicaid participating states must provide coverage, from the point at which pregnancy is established through the last day of the month in which the 60th postpartum day occurs, to all pregnant women whose household income does not exceed 138 percent of FPL ($30,305 for a family of 3 in the 48 contiguous United States and the District of Columbia in 2021). *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), (*l*)(1)–(2). States may, at their option, extend Medicaid and CHIP to additional pregnant/postpartum women and children deemed eligible based on their household incomes. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(IX). States may also expand eligibility for a narrow benefit package of family planning and "family planning related" services. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI), (B)(ii). This option offers limited coverage, but is significantly less protective of overall health than full Medicaid coverage in states that have expanded

Medicaid under the ACA, per 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). For poor women of childbearing age—historically excluded from Medicaid unless pregnant, disabled, or raising children in deep poverty—the ACA expansion represents a vital pathway to comprehensive coverage of health care needs prior to, throughout, and well after pregnancy. KAISER FAMILY FOUNDATION, *Medicaid's Role for Women* 2–5 (2019), https://files.kff.org/attachment/Fact-Sheet-Medicaids-Role-for-Women. Mississippi has not expanded Medicaid, thereby choosing to forgo these crucial health supports.

In Mississippi and the thirteen other high-restriction states, women of reproductive age—if not already pregnant, disabled or a parent—may at best qualify for limited family planning benefits. Within the six non-expansion states, four (including Mississippi) set the Medicaid eligibility rate for parents at less than forty percent FPL. Three of these four states (including Mississippi) limit Medicaid eligibility for parents to twenty-five percent FPL or less, meaning that parents do not qualify for Medicaid in these states if their annual income exceeds—at most— $5,490 for a family of three in 2021.

Medicaid in these high-restriction states is of limited reach even for pregnant women. Across all states, the median income eligibility level for pregnant women is 200 percent FPL; among the fourteen high-restriction states, six—including Mississippi—fall below the median. Even among highly restrictive abortion states with limited investment policies, Mississippi is routinely at or near the bottom in terms of Medicaid availability for young, impoverished women, who, as noted *supra*, are most likely to experience unintended pregnancy.

Moreover, the fourteen high-restriction states similarly restrict financial and nutrition assistance to women, children, and families. The national median monthly TANF payment for a family of three is $492. *See* App. Table 4. Among the fourteen high-restriction states, twelve, including Mississippi, fall below this standard. *Id.* Nationally, 21.7 percent of poor infants receive TANF benefits. Among the most restrictive states, all but Ohio fall below this national average; Mississippi holds the penultimate rank, providing TANF assistance only to 8.6 percent of infants living in the state's poorest households. *Id.*

Of the 6.87 million served by WIC each month in FY 2018, children represented approximately three-quarters of all participants. FNS, *WIC Frequently Asked Questions (FAQs)* (2019), https://www.fns.usda.gov/wic/frequently-asked-questions. Infants consistently have the highest participation rate. FNS, *WIC Eligibility and Coverage Rates* (2018), https://www.fns.usda.gov/wic/eligibility-and-coverage-rates-2018. WIC-eligible women and children must be high risk, either due to "medically-based risks" (e.g. anemia, maternal age, history of pregnancy complications, or poor pregnancy outcomes) or "diet-based risks" linked to inadequate dietary patterns. FNS, *WIC Frequently Asked Questions (FAQs)*, *supra*. Financial eligibility is set at 185 percent of FPL. *Id.* States have considerable flexibility to simplify WIC enrollment and can liberalize the financial eligibility methodologies they use to help boost participation. Committee on Natl. Stat., Natl. Research Council, *Estimating Eligibility and Participation for the WIC Program: Phase I Report*, 15–18 (2001), https://www.ncbi.nlm.nih.gov/books/NBK223572/. Because families can establish WIC eligibility by showing

Medicaid participation, Medicaid eligibility factors also influence WIC participation. Steven Carlson et al., *WIC Participation and Costs are Stable*, Center on Budget & Policy Priorities (2017), at 12, https://www.cbpp.org/research/food-assistance/wic-participation-and-costs-are-stable.

The national average WIC participation standard for eligible women stands at sixty-nine percent. Among the fourteen states that most restrict abortion access, eight fall below this standard. *See* App. Table 4.

The high-restriction, low-investment states' purported concern for the well-being of women and children is belied by the degree to which they have rejected investment in the very programs designed to protect women, children, and families. In Mississippi, the substantial harms to public health flowing from the state's violation of women's constitutional right to abortion access are compounded by inadequate health care and social welfare systems that fail women, children and families.

CONCLUSION

Objective evidence overwhelmingly points to abortion access as a necessary tool in promoting health and in mitigating health threats to women and families inherent in unintended, and particularly unwanted, pregnancies. Women depend on abortion access as an essential health safeguard; evidence shows women seeking abortion do so in great part for their health and well-being and that of their families.

Mississippi and thirteen other states that have pursued the most far-reaching and intrusive abortion

policies also demonstrate a consistent and marked failure to invest in maternal and child health, a reality that stands in stark contrast to any claim that a pre-viability abortion ban demonstrates respect for life. A review of key population health indicators underscores the fact that mothers and children in these states experience the worst health outcomes and must face pregnancy, birth, and childhood with the greatest deficit of health, health care, and social supports.

For the foregoing reasons, *Amici* respectfully urge the Court to affirm the decision below.

September 20, 2021

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APPENDIX

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Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia

RANKINGS					
State	Early Entry Into Prenatal Care Ranking‡[1]	Infant Mortality Rate Ranking¥[2]	Low Birthweight Ranking‡[3]	Young Child Poverty (Ages 0-5) Ranking^[4]	Children with 2+ Adverse Childhood Experiences (ACEs) Ranking*[5]
Alabama	47	47	49	46	29
Alaska	35	13	1	20	47
Arizona	42	20	15	38	38
Arkansas	50	39	38	48	51
California	4	3	11	21	4
Colorado	28	12	42	7	20
Connecticut	7	8	20	18	5
Delaware	20	33	43	28	30
DC	49	NA	47	33	43
Florida	37	31	34	36	17
Georgia	38	42	48	37	39
Hawaii	32	17	26	6	7
Idaho	19	7	8	23	31
Illinois	26	22	28	30	8
Indiana	41	36	24	26	32
Iowa	13	16	6	15	23
Kansas	8	25	18	25	24
Kentucky	18	15	32	47	40
Louisiana	39	48	50	50	44
Maine	2	19	14	29	25

Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia, Continued

State	Early Entry Into Prenatal Care Ranking‡[1]	Infant Mortality Rate Ranking¥[2]	Low Birthweight Ranking‡[3]	Young Child Poverty (Ages 0-5) Ranking^[4]	Children with 2+ Adverse Childhood Experiences (ACEs) Ranking[6]
Maryland	46	30	33	9	9
Massachusetts	6	2	16	8	2
Michigan	16	35	35	35	33
Minnesota	11	9	9	4	10
Mississippi	**21**	**49**	**51**	**51**	**41**
Missouri	25	32	37	32	11
Montana	34	10	12	16	48
Nebraska	23	14	17	12	21
Nevada	43	24	36	31	26
New Hampshire	3	1	2	1	12
New Jersey	31	6	22	13	1
New Mexico	48	23	40	49	49
New York	14	5	23	34	3
North Carolina	36	38	41	43	6
North Dakota	22	46	7	2	34
Ohio	33	41	31	40	42
Oklahoma	44	45	25	41	45
Oregon	12	11	5	11	35
Pennsylvania	29	28	30	27	18
Rhode Island	5	26	21	22	19
South Carolina	45	40	45	45	36
South Dakota	30	37	10	24	37
Tennessee	40	44	39	42	27
Texas	51	21	27	39	22
Utah	10	18	13	5	15

Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia, Continued

State	Early Entry Into Prenatal Care Ranking‡[1]	Infant Mortality Rate Ranking¥[2]	Low Birthweight Ranking‡[3]	Young Child Poverty (Ages 0-5) Ranking^[4]	Children with 2+ Adverse Childhood Experiences (ACEs) Ranking*[5]
Vermont	1	NA	4	3	28
Virginia	15	27	29	14	13
Washington	27	4	3	10	14
West Virginia	17	34	44	44	46
Wisconsin	9	29	19	17	16
Wyoming	24	43	46	19	50

Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia, Data for Table 1 State Rankings

DATA FOR TABLE 1 STATE RANKINGS					
State	Early Entry Into Prenatal Care[1]	Infant Mortality Rate[2]	Low Birthweight Births[3]	Young Children in Poverty (Ages 0-5)[4]	Children with 2+ Adverse Childhood Experiences (ACEs)[5]
United States	77.1%	5.60	8.3%	18%	18%
Alabama	71.8%	7.89	10.5%	24%	21%
Alaska	75.0%	4.81	6.3%	16%	26%
Arizona	73.2%	5.24	7.4%	21%	22%
Arkansas	68.4%	6.90	9.2%	26%	29%
California	85.0%	4.06	7.1%	16%	15%
Colorado	77.4%	4.74	9.4%	11%	19%
Connecticut	84.1%	4.42	7.8%	15%	15%
Delaware	78.8%	6.22	9.4%	17%	21%
DC	74.9%	6.01	8.7%	20%	23%

Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia, Data for Table 1 State Rankings

State	Early Entry Into Prenatal Care[1]	Infant Mortality Rate[2]	Low Birthweight Births[3]	Young Children in Poverty (Ages 0-5)[4]	Children with 2+ Adverse Childhood Experiences (ACEs)[5]
Florida	69.5%	NA	9.9%	18%	18%
Georgia	74.8%	6.98	10.0%	20%	22%
Hawaii	75.9%	5.06	8.4%	11%	16%
Idaho	79.0%	4.39	6.9%	17%	21%
Illinois	77.6%	5.52	8.4%	18%	16%
Indiana	73.8%	6.53	8.2%	17%	21%
Iowa	81.1%	5.03	6.8%	15%	20%
Kansas	82.8%	5.69	7.6%	17%	20%
Kentucky	79.0%	5.00	8.7%	26%	22%
Louisiana	74.6%	8.07	10.8%	28%	23%
Maine	85.6%	5.23	7.4%	18%	20%
Maryland	72.0%	5.91	8.7%	12%	16%
Massachusetts	84.4%	3.59	7.6%	12%	14%
Michigan	79.8%	6.33	8.7%	19%	21%
Minnesota	81.8%	4.47	6.9%	11%	16%
Mississippi	78.3%	9.07	12.3%	31%	22%
Missouri	77.6%	6.10	8.8%	18%	16%
Montana	75.3%	4.63	7.3%	15%	26%
Nebraska	78.1%	4.95	7.6%	13%	19%
Nevada	73.1%	5.63	8.8%	18%	20%
New Hampshire	85.3%	3.07	6.4%	7%	16%
New Jersey	76.5%	4.30	7.9%	13%	13%
New Mexico	69.6%	5.61	9.3%	28%	26%
New York	80.7%	4.26	8.1%	19%	14%

Appendix

TABLE 1: States Ranked by Performance on Key Indicators of Women's Health, Maternal Health, and the Health of Infants and Children: 50 States and the District of Columbia, Data for Table 1 State Rankings

State	Early Entry Into Prenatal Care[1]	Infant Mortality Rate[2]	Low Birthweight Births[3]	Young Children in Poverty (Ages 0-5)[4]	Children with 2+ Adverse Childhood Experiences (ACEs)[5]
North Carolina	74.9%	6.80	9.3%	22%	15%
North Dakota	78.1%	7.35	6.8%	10%	21%
Ohio	75.4%	6.97	8.6%	21%	22%
Oklahoma	72.8%	7.08	8.2%	22%	25%
Oregon	81.2%	4.69	6.7%	13%	21%
Pennsylvania	77.3%	5.85	8.4%	17%	18%
Rhode Island	84.9%	5.80	7.8%	16%	18%
South Carolina	72.0%	6.97	9.8%	22%	21%
South Dakota	76.8%	6.68	7.0%	17%	21%
Tennessee	74.2%	7.06	9.2%	22%	20%
Texas	67.0%	5.49	8.4%	21%	19%
Utah	82.1%	5.13	7.4%	11%	17%
Vermont	89.5%	NA	6.6%	11%	20%
Virginia	79.9%	5.82	8.4%	14%	16%
Washington	77.5%	4.14	6.4%	13%	16%
West Virginia	79.2%	6.31	9.8%	22%	25%
Wisconsin	82.5%	5.85	7.6%	15%	17%
Wyoming	77.8%	7.00	9.8%	15%	26%

Appendix

TABLE 1 NOTES:

‡ "Early entry into prenatal care" means commencement of prenatal care in first trimester of pregnancy. States are ranked from highest to lowest percentage of patients with early entry.

¥ "Infant mortality rate" means the number of infant deaths before age 1 per 1000 live births. States are ranked from lowest to highest infant mortality rate.

± "Low birthweight" means infants weighing less than 5.5 lbs (2500 grams) at the time of birth. States are ranked from lowest to highest low birthweight birth percentage.

∧ "Young children in poverty" means children ages 0-5 living in families with incomes up to 100% FPL in CY 2019 ($25,926 for a family of 4 in the 48 contiguous states and the District of Columbia). Child poverty is ranked from lowest to highest.

℘ "Children with 2+ Adverse Childhood Experiences (ACES)" means that a child has experienced 2 or more conditions considered by experts to have a significant adverse impact on child health and well-being, and with long term consequences. Children with 2+ ACEs are ranked from lowest to highest.

SOURCES:

[1] Centers for Disease Control & Prevention, *National Vital Statistics Reports: Timing and Adequacy of*

Prenatal Care in the United States (2018), https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_03.pdf.

[2] Centers for Disease Control & Prevention, *2019 Infant Mortality Rate by State* (2021), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

[3] Centers for Disease Control & Prevention, *National Vital Statistics Reports: 2019 Births* (2021), https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm.

[4] Kids Count Data Center, *2019 Children in Poverty by Age Group in the United States* (2020) (analysis of data from the U.S. Census Bureau, American Community Survey), https://datacenter.kidscount.org/data/tables/5650-children-in-poverty-by-age-group?loc=1&loct=2#detailed/2/2-53/false/1729/17/12264.

[5] Data Resource Center For Child And Adolescent Health, *2018-2019 National Survey of Children's Health* (2021) (data query: *Indicator 6.13, Has this child experienced one or more adverse childhood experiences from the list of 9 ACEs?*), https://www.childhealthdata.org/browse/survey/allstates?q=7915.

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[3]	Maximum Medicaid Income Eligibility Level for Parents*[4]	Maximum Medicaid Income Eligibility Level for Children‡[5]	% Women Eligible for WIC Who Receive Benefits‡[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits√[7]	Monthly TANF Benefit for a Family of Three√[8]	Pregnant Women Eligible for TANF if No Other Child√[9]
United States	Yes: 38 states + DC No: 12 states	Yes: 27 states No: 23 states + DC	200%*	138%*	255%*	69%**	21.7%**	$492*	State provides benefit within the 1st trimester or month of medical verification: 10
AL	No	Yes	146%	18%	317%	70%	14.6%	$215	No
AK	Yes	No	205%	138%	208%	72%	21.0%	$923	Yes, eligible at 7 months pregnant
AZ	Yes	No	161%	138%	205%	61%	5.2%	$278	No
AR	Yes	No	214%	138%	216%	67%	5.8%	$204	No

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women[3]	Maximum Medicaid Income Eligibility Level for Parents[4]	Maximum Medicaid Income Eligibility Level for Children[5]	% Women Eligible for WIC Who Receive Benefits[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[7]	Monthly TANF Benefit for a Family of Three[8]	Pregnant Women Eligible for TANF if No Other Child[9]
CA	Yes	Yes	322%	138%	266%	73%	71.9%	$878	Yes, eligible at 4 months pregnant
CO	Yes	No	265%	138%	265%	60%	28.4%	$508	Yes, eligible from month of medical verification
CT	Yes	Yes	263%	160%	323%	57%	39.0%	$698	Yes, eligible at 1 month pregnant
DE	Yes	No	217%	138%	217%	64%	35.6%	$338	Yes, eligible at 9 months pregnant
DC	Yes	No	324%	221%	324%	57%	88.2%	$658	Yes, eligible at 5 months pregnant
FL	No	Yes	196%	31%	215%	72%	8.3%	$303	Yes, eligible at 9 months pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[3]	Maximum Medicaid Income Eligibility Level for Parents‡[4]	Maximum Medicaid Income Eligibility Level for Children‡[5]	% Women Eligible for WIC Who Receive Benefits‡[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[7]	Monthly TANF Benefit for a Family of Three[8]	Pregnant Women Eligible for TANF if No Other Child[9]
GA	No	Yes	225%	35%	252%	65%	2.9%	$280	No
HI	Yes	No	196%	138%	313%	70%	23.4%	$610	Yes, eligible at 9 months pregnant
ID	Yes	No	138%	138%	190%	60%	2.7%	$309	Yes, eligible at 7 months pregnant
IL	Yes	No	213%	138%	318%	59%	5.3%	$533	Yes, eligible at 1 month pregnant
IN	Yes	Yes	213%	138%	255%	70%	4.8%	$288	No
IA	Yes	No	380%	138%	380%	81%	26.2%	$426	No
KS	No	No	171%	38%	232%	53%	17.5%	$429	Yes, eligible at 1 month pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working Age Adults With Incomes Up to 138% FPL[2]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women[3]	Maximum Medicaid Income Eligibility Level for Parents[4]	Maximum Medicaid Income Eligibility Level for Children[5]	% Women Eligible for WIC Who Receive Benefits[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[7]	Monthly TANF Benefit for a Family of Three[8]	Pregnant Women Eligible for TANF if No Other Child[9]
KY	Yes	No	200%	138%	218%	73%	18.8%	$262	No
LA	Yes	Yes	214%	138%	255%	65%	4.7%	$240	Yes, eligible at 6 months pregnant
ME	Yes	Yes	214%	138%	213%	75%	14.8%	$610	Yes, eligible at 7 months pregnant
MD	Yes	Yes	264%	138%	322%	80%	44.8%	$727	Yes, eligible at 1 month pregnant
MA	Yes	No	205%	138%	305%	74%	65.5%	$633	Yes, eligible at 6 months pregnant
MI	Yes	No	200%	138%	217%	75%	9.7%	$492	Yes, eligible at 1 month pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[3]	Maximum Medicaid Income Eligibility Level for Parents‡[4]	Maximum Medicaid Income Eligibility Level for Children‡[5]	% Women Eligible for WIC Who Receive Benefits‡[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits‡[7]	Monthly TANF Benefit for a Family of Three‡[8]	Pregnant Women Eligible for TANF if No Other Child‡[9]
MN	Yes	Yes	283%	138%	288%	76%	27.4%	$632	Yes, eligible at 1 month pregnant
MS	No	Yes	199%	25%	214%	73%	8.6%	$170	No
MO	Yes	No	305%	138%***	305%	74%	16.1%	$292	No
MT	Yes	Yes	162%	138%	266%	60%	29.9%	$588	Yes, eligible at 7 months pregnant
NE	Yes	No	202%	138%	218%	56%	20.4%	$468	Yes, eligible at 7 months pregnant
NV	Yes	No	165%	138%	205%	59%	16.3%	$386	Yes, eligible at 6 months pregnant
NH	Yes	Yes	201%	138%	323%	44%	40.9%	$1,086	No

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[A2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[3]	Maximum Medicaid Income Eligibility Level for Parents‡[4]	Maximum Medicaid Income Eligibility Level for Children‡[5]	% Women Eligible for WIC Who Receive Benefits‡[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits‡[7]	Monthly TANF Benefit for a Family of Three‡[8]	Pregnant Women Eligible for TANF if No Other Child‡[9]
NJ	Yes	Yes	205%	138%	355%	64%	13.2%	$559	No
NM	Yes	Yes	255%	138%	305%	54%	32.1%	$447	Yes, eligible at 7 months pregnant
NY	Yes	Yes	223%	138%	405%	73%	45.1%	$789	Yes, eligible from month of medical verification
NC	No	Yes	201%	41%	216%	73%	4.7%	$272	No
ND	Yes	No	162%	138%	175%	54%	13.5%	$486	Yes, eligible at 6 months pregnant
OH	Yes	No	205%	138%	211%	65%	28.3%	$505	Yes, eligible at 6 months pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women[3]	Maximum Medicaid Income Eligibility Level for Parents[4]	Maximum Medicaid Income Eligibility Level for Children[5]	% Women Eligible for WIC Who Receive Benefits[6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[7]	Monthly TANF Benefit for a Family of Three[8]	Pregnant Women Eligible for TANF if No Other Child[9]
OK	Yes	Yes	210%	138%	210%	77%	12.0%	$292	No
OR	Yes	Yes	190%	138%	305%	77%	27.3%	$506	Yes, eligible at 8 months pregnant
PA	Yes	Yes	220%	138%	319%	68%	41.1%	$421	Yes, eligible at 1 month pregnant
RI	Yes	Yes	258%	138%	266%	54%	28.0%	$554	Yes, eligible at 7 months pregnant
SC	No	Yes	199%	67%	213%	67%	15.5%	$299	No
SD	No	No	138%	48%	209%	65%	10.8%	$615	No
TN	No	No	255%	93%	255%	69%	23.1%	$277	Yes, eligible at 6 months pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working Age Adults With Incomes Up to 138% FPL[1]	State Provides Expanded Medicaid Family Planning Coverage[^2]	Maximum Medicaid Income Eligibility Limit for Pregnant Women[‡3]	Maximum Medicaid Income Eligibility Level for Parents[‡4]	Maximum Medicaid Income Eligibility Level for Children[‡5]	% Women Eligible for WIC Who Receive Benefits[±6]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[√7]	Monthly TANF Benefit for a Family of Three[√8]	Pregnant Women Eligible for TANF if No Other Child[√9]
TX	No	Yes	207%	17%	206%	74%	5.9%	$303	No
UT	Yes	No	144%	138%	205%	52%	16.0%	$498	Yes, eligible at 7 months pregnant
VT	Yes	No	213%	138%	317%	76%	32.5%	$699	Yes, eligible at 9 months pregnant
VA	Yes	Yes	205%	138%	205%	56%	14.3%	$508	No
WA	Yes	Yes	198%	138%	317%	60%	19.1%	$569	Yes, eligible at 1 month pregnant
WV	Yes	No	305%	138%	305%	80%	9.8%	$340	No
WI	No	Yes	306%	100%	306%	66%	22.6%	$653	Yes, eligible at 6 months pregnant

Appendix

TABLE 2: State Policies Related to Key Investments in Health and Health Care Services for Women of Childbearing Age, Women Who are Pregnant, Infants, Children, and Families: 50 States and the District of Columbia, Continued

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[z]	State Provides Expanded Medicaid Family Planning Coverage[aa]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[ab]	Maximum Medicaid Income Eligibility Level for Parents‡[ac]	Maximum Medicaid Income Eligibility Level for Children‡[ad]	% Women Eligible for WIC Who Receive Benefits‡[ae]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[v][af]	Monthly TANF Benefit for a Family of Three[v][ag]	Pregnant Women Eligible for TANF if No Other Child[v][ah]
WY	No	Yes	159%	52%	205%	68%	4.0%	$712	No

TABLE 2 NOTES:

¥ As authorized by 42 U.S.C. § 1396a(a)(10)(A)(1)(VIII).

∧ As authorized by 42 U.S.C. § 1396a(a)(10(A)(ii)(XXI) or on a demonstration basis under 42 U.S.C. § 1315(a).

‡ As authorized under Medicaid and the Children's Health Insurance Program (CHIP). Eligibility levels are reported as percentage of the FPL. The 2021 FPL for a family of three was $21,960.

℗ As authorized under Medicaid. Eligibility levels are reported as percentage of the FPL. The 2021 FPL for a family of three was $21,960.

± Special Supplemental Nutrition Program for Women, Infants, and Children. As used in WIC, the term "Women" includes pregnant, postpartum non-breastfeeding, and postpartum breastfeeding women.

√ TANF refers to the Temporary Assistance for Needy Families program.

* Median value for the United States.

** Average value for the United States.

*** Missouri implemented expansion on August 10, 2021, with coverage available as of July 1, 2021, according to an order implementing a state Supreme Court decision. *See Doyle v. Tidball*, 625 S.W.3d 459 (Mo. 2021), *affirming*

in part, vacating in part *Doyle v. Tidball*, No. 21AC-CC00186-01, 2021 WL 2629499 (Mo. Cir. June 23, 2021).

SOURCES:

[1] KAISER FAMILY FOUNDATION, *State Health Facts, Status of State Action on Medicaid Expansion Decision* (2021), https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] GUTTMACHER INSTITUTE, *State Laws and Policies, Medicaid Family Planning Eligibility Expansions* (2021), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[3] KAISER FAMILY FOUNDATION, *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level* (2021), https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] KAISER FAMILY FOUNDATION, *Medicaid Income Eligibility Limits for Parents, 2002-2021* (2021), https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] Kaiser Family Foundation *Medicaid/CHIP Upper Income Eligibility Limits for Children, 2000-2021* (2021), https://www.kff.org/medicaid/state-indicator/medicaidchip-upper-income-eligibility-limits-for-children/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] U.S. Dept. of Agriculture, *WIC Eligibility and Coverage Rates, National WIC Eligibility and Participation, 2007-2018* (2018), https://www.fns.usda.gov/wic/eligibility-and-coverage-rates-2018#5.

[7] Zero to Three, *TANF at 25: Poverty Remains High Among the Nation's Babies, But Few are Assisted* (2021), https://www.zerotothree.org/resources/4190-tanf-at-25-poverty-remains-high-among-the-nation-s-babies-but-few-are-assisted.

[8] Center on Budget & Policy Priorities, *TANF Benefits Still Too Low to Help Families, Especially Black Families, Avoid Increased Hardship* (2020), https://www.cbpp.org/research/family-income-support/tanf-benefits-still-too-low-to-help-families-especially-black.

[9] Urban Institute, *Welfare Rules Databook: State TANF Policies as of July 2019* (2021), https://www.urban.org/research/publication/welfare-rules-databook-state-tanf-policies-july-2019.

Appendix

TABLE 3: State Rankings Among States Adopting Seven or More Abortion Restrictions, Including a Ban at a Specific Gestational Age

State	Early Entry Into Prenatal Care Ranking‡[2]	Infant Mortality Rate Ranking¥[3]	Low Birthweight Ranking±[4]	Young Child Poverty (Ages 0-5) Ranking^[5]	Children with 2+ Adverse Childhood Experiences (ACEs) Ranking#[6]
Alabama	47	47	49	46	29
Arkansas	50	39	38	48	51
Indiana	41	36	24	26	32
Kansas	8	25	18	25	24
Kentucky	18	15	32	47	40
Louisiana	39	48	50	50	44
Mississippi	**21**	**49**	**51**	**51**	**41**
Nebraska	23	14	17	12	21
North Dakota	22	46	7	2	34
Ohio	33	41	31	40	42
Oklahoma	44	45	25	41	45
South Carolina	45	40	45	45	36
South Dakota	30	37	10	24	37
Texas	51	21	27	39	22

TABLE 3 NOTES:

† The 7 categories of abortion restrictions include: 1) counseling requirements, 2) waiting periods, 3) ultrasound requirements, 4) parental notification and consent requirements, 5) gestational limits, 6) restrictions on insurance coverage for abortion (includes Medicaid restrictions in addition to those through federal law), and 7) state regulations of facilities and clinicians providing abortions.

‡ "Early entry into prenatal care" means commencement of prenatal care in first trimester of pregnancy. States are ranked from highest to lowest percentage of patients with early entry.

¥ "Infant mortality rate" means the number of infant deaths before age 1 per 1000 live births. States are ranked from lowest to highest infant mortality rate.

± "Low birthweight" means infants weighing less than 5.5 lbs (2500 grams) at the time of birth. States are ranked from lowest to highest low birthweight birth percentage.

∧ "Young children in poverty" means children ages 0-5 living in families with incomes up to 100% FPL in CY 2019 ($25,926 for a family of 4 in the 48 contiguous states and the District of Columbia). Child poverty is ranked from lowest to highest.

℘ "Children with 2+ Adverse Childhood Experiences (ACES)" means that a child has experienced 2 or more

conditions considered by experts to have a significant adverse impact on child health and well-being, and with long term consequences. Children with 2+ ACEs are ranked from lowest to highest.

SOURCES:

[1] Data for all 7 categories were compiled from the following sources: GUTTMACHER INSTITUTE, *State Bans on Abortions Throughout Pregnancy* (2021), https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions; KAISER FAMILY FOUNDATION, *How State Policies Shape Access to Abortion Coverage* (2021), https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/; GUTTMACHER INSTITUTE, *State Policies in Brief, Counseling and Waiting Periods for Abortion* (2021), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion; GUTTMACHER INSTITUTE, *State Policies in Brief, Requirements for Ultrasound* (2021), https://www.guttmacher.org/state-policy/explore/requirements-ultrasound; GUTTMACHER INSTITUTE, *Parental Involvement in Minors' Abortions* (2021), https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions; GUTTMACHER INSTITUTE, *State Policies in Brief, Targeted Regulation of Abortion Providers* (2021), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers.

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[6] Data Resource Center For Child And Adolescent Health, *2018-2019 National Survey of Children's Health* (2021) (data query: *Indicator 6.13, Has this child experienced one or more adverse childhood experiences from the list of 9 ACEs?*), https://www.childhealthdata.org/browse/survey/allstates?q=7915.

Appendix

TABLE 4: State Policies Among States Adopting Seven or More Abortion Restrictions, Including a Ban at a Specific Gestational Age†[1]

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[2]	State Provides Expanded Medicaid Family Planning Coverage[3]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[4]	Maximum Medicaid Income Eligibility Level for Parents*[5]	Maximum Medicaid Income Eligibility Level for Children‡[4]	% Women Eligible for WIC Who Receive Benefits‡[7]	% Infants Up to Age 1 Whose Families Receive TANF Benefits√[8]	Monthly TANF Benefit for a Family of Three√[9]	Pregnant Women Eligible for TANF if No Other Child√[10]
United States	Yes: 38 states + DC No: 12 states	Yes: 27 states No: 23 states + DC	200%*	138%*	255%*	69%**	21.7%**	$492*	State provides benefit within the 1st trimester or month of medical verification: 10
AL	No	Yes	146%	18%	317%	70%	14.6%	$215	No
AK	Yes	No	214%	138%	216%	67%	5.8%	$204	No
IN	Yes	Yes	213%	138%	255%	70%	4.8%	$288	No
KS	No	No	171%	38%	232%	53%	17.5%	$429	Yes, eligible at 1 month pregnant

Appendix

TABLE 4: State Policies Among States Adopting Seven or More Abortion Restrictions, Including a Ban at a Specific Gestational Age, Continued†[1]

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[2]	State Provides Expanded Medicaid Family Planning Coverage[^3]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[4]	Maximum Medicaid Income Eligibility Level for Parents‡[5]	Maximum Medicaid Income Eligibility Level for Children‡[6]	% Women Eligible for WIC Who Receive Benefits‡[7]	% Infants Up to Age 1 Whose Families Receive TANF Benefits√[8]	Monthly TANF Benefit for a Family of Three√[9]	Pregnant Women Eligible for TANF if No Other Child√[10]
KY	Yes	No	200%	138%	218%	73%	18.8%	$262	No
LA	Yes	Yes	214%	138%	255%	65%	4.7%	$240	Yes, eligible at 6 months pregnant
MS	**No**	**Yes**	**199%**	**25%**	**214%**	**73%**	**8.6%**	**$170**	**No**
NE	Yes	No	202%	138%	218%	56%	20.4%	$468	Yes, eligible at 7 months pregnant
ND	Yes	No	162%	138%	175%	54%	13.5%	$486	Yes, eligible at 6 months pregnant
OH	Yes	No	205%	138%	211%	65%	28.3%	$505	Yes, eligible at 6 months pregnant
OK	Yes	Yes	210%	138%	210%	77%	12.0%	$292	No
SC	No	Yes	199%	67%	213%	67%	15.5%	$299	No

Appendix

TABLE 4: State Policies Among States Adopting Seven or More Abortion Restrictions, Including a Ban at a Specific Gestational Age, Continued†[1]

State	State Provides Medicaid Coverage for Working-Age Adults With Incomes Up to 138% FPL[2]	State Provides Expanded Medicaid Family Planning Coverage[^,3]	Maximum Medicaid Income Eligibility Limit for Pregnant Women‡[4]	Maximum Medicaid Income Eligibility Level for Parents[5]	Maximum Medicaid Income Eligibility Level for Children‡[6]	% Women Eligible for WIC Who Receive Benefits‡[7]	% Infants Up to Age 1 Whose Families Receive TANF Benefits[8]	Monthly TANF Benefit for a Family of Three[9]	Pregnant Women Eligible for TANF if No Other Child[10]
SD	No	No	138%	48%	209%	65%	10.8%	$615	No
TX	No	Yes	207%	17%	206%	74%	5.9%	$303	No

TABLE 4 NOTES:

† The seven categories of abortion restrictions include: 1) counseling requirements, 2) waiting periods, 3) ultrasound requirements, 4) parental notification and consent requirements, 5) gestational limits, 6) restrictions on insurance coverage for abortion (includes Medicaid restrictions in addition to those through federal law), and 7) state regulations of facilities and clinicians providing abortions.

¥ As authorized by 42 U.S.C. § 1396a(a)(10)(A)(1)(VIII).

∧ As authorized by 42 U.S.C. § 1396a(a)(10(A)(ii)(XXI) or on a demonstration basis under 42 U.S.C. § 1315(a).

‡ As authorized under Medicaid and the Children's Health Insurance Program (CHIP). Eligibility levels are reported as percentage of the FPL. The 2021 FPL for a family of three was $21,960.

℘ As authorized under Medicaid. Eligibility levels are reported as percentage of the FPL. The 2021 FPL for a family of three was $21,960.

± Special Supplemental Nutrition Program for Women, Infants, and Children. As used in WIC, the term "Women" includes pregnant, postpartum non-breastfeeding, and postpartum breastfeeding women.

√ TANF refers to the Temporary Assistance for Needy Families program.

* Median value for the United States.

** Average value for the United States.

SOURCES:

[1] Data for all 7 categories were compiled from the following sources: Guttmacher Institute, S*tate Bans on Abortions Throughout Pregnancy* (2021), https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions; Kaiser Family Foundation, *How State Policies Shape Access to Abortion Coverage* (2021), https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/; Guttmacher Institute, *State Policies in Brief, Counseling and Waiting Periods for Abortion* (2021), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion; Guttmacher Institute, *State Policies in Brief, Requirements for Ultrasound* (2021), https://www.guttmacher.org/state-policy/explore/requirements-ultrasound; Guttmacher Institute, *Parental Involvement in Minors' Abortions* (2021), https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions; Guttmacher Institute, *State Policies in Brief, Targeted Regulation of Abortion Providers* (2021), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers.

[2] Kaiser Family Foundation, *State Health Facts, Status of State Action on Medicaid Expansion Decision* (2021), https://www.kff.org/health-reform/state-indicator/

state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22-asc%22%7D.

[3] GUTTMACHER INSTITUTE, *State Laws and Policies, Medicaid Family Planning Eligibility Expansions* (2021), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

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[5] KAISER FAMILY FOUNDATION, *Medicaid Income Eligibility Limits for Parents, 2002-2021* (2021), https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] KAISER FAMILY FOUNDATION, *Medicaid/CHIP Upper Income Eligibility Limits for Children*, 2000-2021 (2021), https://www.kff.org/medicaid/state-indicator/medicaidchip-upper-income-eligibility-limits-for-children/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] U.S. Dept. of Agriculture, *WIC Eligibility and Coverage Rates, National WIC Eligibility and Participation, 2007-2018* (2018), https://www.fns.usda.gov/wic/eligibility-and-coverage-rates-2018#5.

[8] Zero to Three, *TANF at 25: Poverty Remains High Among the Nation's Babies, But Few are Assisted* (2021), https://www.zerotothree.org/resources/4190-tanf-at-25-poverty-remains-high-among-the-nation-s-babies-but-few-are-assisted.

[9] Center on Budget & Policy Priorities, *TANF Benefits Still Too Low to Help Families, Especially Black Families, Avoid Increased Hardship* (2020), https://www.cbpp.org/research/family-income-support/tanf-benefits-still-too-low-to-help-families-especially-black.

[10] URBAN INSTITUTE, *Welfare Rules Databook: State TANF Policies as of July 2019* (2021), https://www.urban.org/research/publication/welfare-rules-databook-state-tanf-policies-july-2019.