No. 20-6267

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRISTOL REGIONAL WOMEN'S CENTER, P.C., *et al.*,
Plaintiffs-Appellees,
—v.—
HERBERT H. SLATERY III, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court for the
Middle District of Tennessee
(No. 3:15-cv-00705)

BRIEF FOR SISTERREACH AND THIRTEEN OTHER REPRODUCTIVE JUSTICE AND HEALTH ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Under Federal Rule of Appellate Procedure 26.1 and 6th Cir. R. 26.1, *amici curiae* SisterReach, Feminist Women's Health Center, Healthy and Free Tennessee, In Our Own Voice: National Black Women's Reproductive Justice Agenda, Medical Students for Choice, SisterLove, Inc., SPARK Reproductive Justice NOW!, National Birth Equity Collaborative, National Health Law Program, National Women's Law Center, Southern AIDS Coalition, Walking Into a New Life, Women Engaged, and Women with a Vision state that:

1. None of them is a subsidiary or affiliate of a publicly owned corporation; and
2. There are no publicly owned corporations, not a party to the appeal, that have a financial interest in the outcome.

CERTIFICATE OF SERVICE

I certify that on April 8, 2021, the foregoing document was served on all counsel of record through the CM/ECF system.

/s/ *Sarah Mac Dougall*
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INTEREST OF AMICUS CURIAE

Amici are advocates of reproductive justice. The term reproductive justice was coined in Chicago in 1994 by twelve Black women, to center the lived experiences of Black women and other marginalized individuals regarding issues of reproductive and sexual health and justice. The framework is grounded in Black feminist and human rights theory. Central to the framework are the human rights to dignity, self-determination, and autonomy.[1] The goal of reproductive justice advocates is to protect the human rights of women, people who give birth, and their families.[2]

SisterReach is a Tennessee-based grassroots organization dedicated to protecting the reproductive and sexual autonomy of women and teens of color, poor and rural women, LGBT+, Gender Non-Conforming individuals and their families through the framework of reproductive justice. SisterReach's mission is to empower its base to lead healthy lives, raise healthy families and live in healthy and sustainable communities. SisterReach works from a four-pronged strategy of education, policy and advocacy, culture shift, and harm reduction.

Feminist Women's Health Center is a Black woman-led, independent, non-profit, multi-generational, multi-racial reproductive health, rights, and justice

[1] *See* Loretta J. Ross & Rickie Solinger, *Reproductive Justice: An Introduction* (2017).

[2] *Amici* recognize that abortion restrictions impact not just cisgender women, but rather all people who can become pregnant.

organization committed to a vision of accessible and judgment-free reproductive health care and access in the South for all who need it. Based in Atlanta, GA, FWHC offers compassionate abortion care as part of comprehensive reproductive health services and works to improve access for traditionally underserved communities.

Healthy and Free Tennessee promotes sexual and reproductive health and freedom in Tennessee by advancing policies and practices which recognize these elements as essential to the overall well-being of all individuals and communities. It envisions a future where all Tennesseans are healthy, have privacy, are empowered to make the best decisions for themselves and their communities within their own moral and faith traditions, and have access to the resources they need to make informed choices about their lives.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national organization focused on lifting up the voices of Black women at the national and regional levels in our ongoing fight to secure Reproductive Justice for all women, girls and gender expansive people. It approaches policy issues from a human rights perspective that asserts Black women's right to have full agency and autonomy over their bodies, gender, sexuality, labor and reproduction.

Medical Students for Choice has worked for over 25 years to create tomorrow's abortion providers and pro-choice physicians. It has student-led chapters at East Tennessee State University's Quillen College of Medicine, Lincoln

Memorial University-DeBusk College of Osteopathic Medicine, Meharry Medical College, and Vanderbilt University School of Medicine.

SisterLove, Inc. is the first women's HIV/AIDS and reproductive justice organization in the southeastern United States. It works to eradicate the adverse impact of HIV/AIDS and other reproductive health challenges upon women and their families, youth of color, and LGBTQ+ individuals.

SPARK Reproductive Justice NOW! works to build and strengthen the power of communities and a reproductive justice movement that centers Black Women, Women of Color, and Queer & Trans Youth of Color in Georgia and the South. Based in Atlanta, it has fostered a dynamic, collaborative model of advocacy, leadership development, collective action, and discourse that creates change and impact for Black women and queer people's struggles for reproductive justice.

The National Birth Equity Collaborative is dedicated to eliminating racial disparities in maternal and birth outcomes and advancing birth equity by creating solutions that optimize Black maternal and infant health through training, research, policy advocacy, and community-centered collaboration.

The National Health Law Program advocates, educates, and litigates at the federal and state levels to further its mission of improving access to quality health care for low-income individuals and underserved communities and populations.

The National Women's Law Center is a legal nonprofit organization dedicated to the advancement and protection of the legal rights and opportunities of women and all who suffer from sex discrimination. It focuses on issues of key importance to women and their families, including economic security, employment, education, health, and reproductive rights, with particular focus on the needs of low-income women and those who face multiple and intersecting forms of discrimination.

The Southern AIDS Coalition is a regional organization serving the sixteen southern states and Washington, DC, with a mission to end the HIV and STI epidemics in the South by promoting accessible and high-quality systems of prevention, treatment, care, housing, and essential support services – including access to comprehensive reproductive health care.

Walking Into a New Life is a Memphis, Tennessee-based organization that assists individuals impacted by domestic violence to navigate a safe path towards independence to include tangible resources, peer support and financial sustainability.

Women Engaged is an Atlanta-based grassroots organization, created at the intersection of reproductive justice and civic engagement. It centers the issues paramount to Black women and girls to build the power where compassionate, fact-based, equity-centered approaches are used to develop and implement public policy

and actualize social transformation. Its programs prioritize reproductive, racial, and economic justice for marginalized people.

Women With A Vision is New Orleans's premier women's health organization, combining service and advocacy to address the social conditions and injustices that impact our city's most marginalized women. It strives, through relentless advocacy, health education, supportive services, and community-based, participatory research, to improve the lives of marginalized women, their families, and communities.

Under Federal Rule of Appellate Procedure 29(a)(2), *Amici* file this *amicus curiae* brief with the consent of all parties. No counsel for any party authored this brief in whole or in part, and no person or entity, other than *Amici* and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION

The district court correctly found that Tennessee's 48-hour mandatory waiting period law, Tenn. Code Ann. § 39-15-202(a)–(h) (the "Delay Law"), is an unnecessary health regulation that has the "purpose or effect" of presenting a substantial obstacle to people seeking an abortion. *Amici* write to highlight the unconstitutional nature of *both* the Delay Law's purpose *and* its effect, particularly as the State's actions bear on the health and welfare of Black people, Indigenous people, and people of color ("BIPOC"), vulnerable individuals, and their children.

First, the Delay Law's stated purpose of protecting maternal health is belied by the State's egregious failure to address a maternal and infant health crisis that disproportionately harms BIPOC. Tennessee (1) has some of the worst and most racially inequitable maternal and infant health outcomes in the country, (2) has refused to adopt legislation that would protect maternal health and support the decision to have children, (3) has resolutely prohibited effective sexual and reproductive education that would reduce maternal and infant mortality and promote positive health outcomes, and (4) has adopted some of the most restrictive anti-abortion laws in the country. Viewed against this background, the State's claim that the Delay Law was intended to protect maternal health rather than impose a substantial obstacle to people seeking an abortion is exposed as disingenuous.

Second, the Delay Law's barriers to obtaining an abortion operate as a substantial obstacle to the choices of low-income women, who are "the vast majority of women seeking abortions in Tennessee." *Adams & Boyle, P.C. v. Slatery*, No. 15-cv-705, 2020 WL 6063778, at *61 (M.D. Tenn. Oct. 14, 2020). A waiting period imposes substantial financial and logistical burdens on those who can least afford to bear them. Low-income people are much less likely to be able to take time off from work or pay for child-care, lodging, and travel, and they are more likely to face increased out-of-pocket medical expenses. These are all costs the Delay Law at least doubles by requiring a second visit to an abortion provider and by pushing abortion care to a later gestational age. Further, because of structural racism, pay inequity, and educational inequity, Black and Latina women disproportionately have lower incomes, and so the Delay Law disproportionately affects them as well. Finally, the Delay Law stigmatizes women by perpetuating harmful stereotypes about their supposed inability to make their own health care decisions and racist narratives that women of color lack the capacity to make their own decisions about fundamental life activities.

For all of these reasons, this Court should affirm the district court's ruling enjoining enforcement of the Delay Law.

ARGUMENT

I. Tennessee's Claim That The Delay Law's Purpose Is To "Promote Maternal Health" Is Disingenuous.

State laws "'that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right'" to choose. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2296 (2016) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)). The Supreme Court applied this principle just last year. *June Medical Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2112 (2020); *id*. at 2133 (Roberts, C.J., concurring).

The parties in this case disagree on whether a law's effects should be evaluated by balancing its actual benefits and burdens after Chief Justice Roberts's separate opinion rejected such a balancing test. *See id.* at 2135–36 (Roberts, C.J.).[3] But there is no dispute that a law with the *purpose* to impose a substantial obstacle to a woman seeking an abortion is unconstitutional. Appellants' Br., Dkt. No. 28 at 33–34. Tennessee's claim that the Delay Law's purpose is to promote maternal health is disingenuous. The State faces a maternal and infant health crisis it has failed to address, while adopting policies that exacerbate the underlying causes of that crisis.

[3] For the reasons stated in Plaintiffs-Appellee's merits brief, *amici* believe Chief Justice Roberts's concurrence is not controlling.

A. Tennessee Has One of the Highest Rates of Infant and Maternal Death in the United States, and Black Women and Their Children Are Most Affected.

Maternal and infant mortality rates are higher in the United States than in other developed countries,[4] and Tennessee is "among the worst performing states for high rates of infant and maternal deaths."[5] Specifically, Tennessee has one of the highest pregnancy-related death rates in the United States: 26 women died from pregnancy-related causes per 100,000 live births in 2018, compared to a national rate of 17.4 per 100,000.[6] Tennessee also is among the ten worst performing states for rates of preterm pregnancies and low birthweight.[7] Relatedly, approximately seven infants die for every 1,000 live births in Tennessee – a rate exceeding the national average

[4] *See* Nina Martin & Renee Montagne, *Special Series: Lost Mothers: Maternal Mortality In The U.S.: Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why,* NPR (Dec. 7, 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why (last visited April 8, 2021).

[5] Anna Lummus & Anna Walton, *Why are Tennessee Moms and Babies Dying at Such a High Rate?*, Tennessee Justice Center, at 1 (Sept. 26, 2018), https://www.tnjustice.org/wp-content/uploads/2018/09/Infant-and-Maternal-Mortality-Policy-Brief.pdf (last visited April 8, 2021).

[6] Ctrs. for Disease Control & Prevention, *Maternal Mortality by State*, (2018), https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf.

[7] Ctrs. for Disease Control & Prevention, S*tats for the State of Tennessee* (Apr. 9, 2018), https://www.cdc.gov/nchs/pressroom/states/tennessee/tennessee.htm.

by 19%.[8] Two counties in Tennessee report infant mortality rates over 20 per 1,000, or one death for every 50 births.[9]

Pregnancy-related death rates for mothers and infants are significantly worse for Black people. In Tennessee, Black infants are over twice as likely to die during birth than white infants,[10] and Black women are three times more likely than white women to die from pregnancy complications.[11] What is more tragic, many of these deaths of Black mothers are preventable: during 2017 and 2018, a medical review body determined that 100% of the pregnancy-related deaths of Black women studied could have been avoided.[12] These disparities in maternal and infant health persist even after controlling for education and income, supporting the conclusion that these disparities are "rooted in racism."[13]

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[8] *See* Ctrs. for Disease Control and Prevention, *Infant Mortality Rates by State* (Apr. 24, 2020), https://www.cdc.gov/nchs/pressroom/sosmap/infantmortalityrates/infant_mortality.htm.

[9] Tenn. Dep't Health, *2020 Child Fatality Annual Report*, at 49–52 (2020), https://www.tn.gov/content/dam/tn/health/documents/child-fatality-reports/2018Child%20Fatality-Review-report %20.pdf.

[10] *Id*.

[11] *See* Tenn. Dept. of Health, *Maternal Mortality Review*, https://www.tn.gov/health/health-program-areas/fhw/maternal-mortality-review.html (last visited April 8, 2021).

[12] *Id*.

[13] Jamila Taylor et al., *Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint*, Center for American Progress (May 2, 2019), https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/ (last visited April

B. Tennessee Has Repeatedly Refused to Adopt Policies Supporting the Decision to Have Children or Protecting Maternal Health.

Despite its professed concern for "maternal health," Tennessee has failed to take steps to address its maternal and infant mortality crisis. In Tennessee, 39% of women receive delayed or no pre-natal care, as compared to 23% of women across the country.[14] And, in the midst of the COVID-19 pandemic, Tennessee cut $6.6 million from its budget for postpartum care, blocking efforts to extend coverage for this type of care from 60 days to one year.[15]

Making matters worse, in 2020 Tennessee failed to pass legislation to expand Medicaid, leaving about 260,000 people without an affordable healthcare coverage

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8, 2021); *Table 012: Infant Mortality Rates, by Race and Hispanic Origin of Mother, State, and Territory: United States and U.S. Dependent Areas, Average Annual 1989–1991, 2003–2005, and 2012–2014, 2016*, Nat'l Center for Health Statistics, https://www.cdc.gov/nchs/data/hus/2016/012.pdf (last visited April 8, 2021).

[14] Chattanooga-Hamilton County Health Department, *Picture of Our Health: Hamilton County Community Health Profile, 2019*, at 36, http://health.hamiltontn.org/Portals/14/DataPublications/Docs/2019%20Report%20Final%202019-02-28.docx.pdf (last visited April 8, 2021).

[15] *Multi-Year Approach to a Structurally Balanced Budget, FY21 June Adjusment* [*sic*] *Schedule 060420*, June 3, 2020, https://www.tn.gov/content/dam/tn/finance/budget/documents/overviewspresentations/FY21JuneAdjusmentSchedule060420.pdf.

option.[16] Tennessee has also refused to raise the minimum wage,[17] purged children of low-income families from TennCare (leaving parents scrambling to afford resources for essential prevention services like teeth cleanings, physicals, and immunizations),[18] and drastically reduced SNAP benefits.[19] In Tennessee, the maximum monthly Temporary Assistance for Needy Families benefit for a family of three (one parent and two children) in Tennessee is $185 per month, while the median cash assistance benefit nationwide is $450.33 per month.[20] Anyone would

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[16] *See Status of State Medicaid Expansion Decisions: Interactive Map*, Kaiser Family Foundation, Nov. 2, 2020, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ (last visited April 8, 2021); Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Foundation, Jan. 21, 2021, https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[17] Jamie McGee, *In Tennessee, minimum wage remains unchanged since 2009, with no bump on the horizon*, The Tennessean (May 2, 2019), https://www.tennessean.com/story/money/2019/05/03/tennessee-minimum-wage-unchanged/3004107002/.

[18] Brett Kelman, *Tennessee erased insurance for at least 128,000 kids. Many parents don't know*, The Tennessean (Apr. 1, 2019), https://www.tennessean.com/story/news/health/2019/04/02/tennessee-tenncare-coverkids-medicaid-erased-health-care-coverage-for-children/3245116002/.

[19] Yolanda Putman, *Food stamp cuts hit home in greater Chattanooga area,* Chattanooga Times Free Press (Nov. 2, 2013), https://www.timesfreepress.com/news/local/story/2013/nov/02/food-stamp-cuts-hit-home/123028/.

[20] Ben Goehring et al., *Welfare Rules Databook: State TANF Policies as of July 2018*, at 117–18, Admin. Children & Families, U.S. Dep't Health & Human Servs. (Aug. 2019), https://www. https://www.urban.org/sites/default/files/publication/101070/welfare_rules_databook_state_tanf_policies_as_of_july_2018.pdf.

struggle to make ends meet in these circumstance, and many Tennesseans are forced to make hard choices to sustain and expand their families.

The lack of access to healthcare and economic instability leaves many pregnant people with few options. In 2014, 42% of abortion patients had incomes at or below the federal poverty level, and 27% had incomes at or below 200% of the poverty level.[21] In a recent study of patients assisted by an abortion fund, "40% of [respondents] already had multiple children, which is consistent with other studies [and *amici*'s experiences], suggesting that abortion patients who are already mothers often seek abortion services in order to provide a stable and economically secure environment for their existing children."[22]

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Tennessee has ignored these urgent medical issues and financial barriers that prevent some people from being able to raise a family. In fact, SisterReach and the other *amici* have observed the reality that Black women and other marginalized individuals in Tennessee often are forced to make the hard choice of terminating

[21] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* at 6, Guttmacher Inst. (2016), https://www. https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[22] G.E. Ely et al., *A trauma-informed examination of the hardships experienced by abortion fund patients in the U.S.*, at 17 (forthcoming 2021 in Health Care for Women International), available at https://pubmed.ncbi.nlm.nih.gov/28850325/.

wanted pregnancies to avoid generational cycles of inequality, and, ultimately, save their own lives and those of their existing children.

C. Tennessee Refuses to Allow Young People Access to Comprehensive Reproductive and Sexual Health Education.

Providing evidence-based reproductive and sexual health education is a highly effective way to reduce maternal mortality, infant mortality, and sexually transmitted diseases.[23] Despite the proven health benefits, Tennessee does not require schools to provide *any* sexual health education, unless county pregnancy rates exceed 19.5 pregnancies for every 1,000 women ages 15 to 17.[24] And any school in Tennessee that provides sexual health education is required to teach students "sexual risk avoidance" programming through an abstinence-based curriculum.[25] Further, in 2012, the Tennessee legislature passed Senate Bill 3310, which prohibits any sexual health education instruction that promotes or condones "gateway sexual activity," defined as "sexual contact encouraging an individual to engage in a non-abstinent behavior," and subjects offenders to civil liability and fines of up to $500.[26]

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[23] *See* SisterReach, *Our Voices & Experiences Matter: The Need for Comprehensive Sex Education Among Young People of Color in the South* at 5, 7 (2015), https://www.sisterreach.org/uploads/1/2/9/0/129019671/2015_sr_our_voices_and_experiences_matte.pdf.

[24] Tenn. Code Ann. § 49-6-1302(a)(1).

[25] Tenn. Code Ann. § 49-6-1304(a)(1).

[26] 2012 Tenn. Laws Pub., ch. 973 (S.B. 3310), *repealing* Tenn. Code Ann. § 49-6-1305 *and amending* Tenn. Code Ann. §§ 49-6-1301–07.

The problem with Tennessee's abstinence-based education is that it does not work. "[P]eople still enact the sexual behaviors that [Tennessee is] trying to keep people from doing . . . oftentimes with less protection, and without the skills to communicate clearly what they want and don't want."[27]

While all young people in Tennessee suffer from the lack of access to comprehensive reproductive and sexual health education, these laws have a disparate impact on young Black people, a group that already faces the highest rates of health disparities in the state.[28] A full 90% of young Black people surveyed by SisterReach in 2015 said they were not given all the information necessary to make fully informed decisions about sex or their bodies.[29] Unsurprisingly, young Black people and other young people of color in Tennessee disproportionately experience higher unintended pregnancy rates and sexually transmitted infection rates.[30]

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[27] Steven Hale, *Sex Issue: Let's Talk About Sex: When it Comes to Teens and Sex, What They Don't Know Can Hurt Them*, Nashville Scene, Oct. 24, 2019, https://www.nashvillescene.com/news/cover-story/article/21093674/sex-issue-lets-talk-aboutsex (last visited April 8, 2021) (internal quotation marks omitted).

[28] SisterReach, *supra* note 23.

[29] *Id.*

[30] *Tennessee State Government, Number of Pregnancies with Rates Per 1,000 Females Aged 10–19, By Race, For Counties of Tennessee*, Resident Data, 2018 https://www.tn.gov/content/dam/tn/health/documents/vital-statistics/pregnancy/2018/TN%20Pregnancy%20Rates%20Age%2010-19%20-%202018.pdf (last visited April 8, 2021).

D. The Delay Law Reflects Tennessee's Efforts to Restrict Access to Abortion.

Not only do Tennessee's failures to address the healthcare needs of families contradict the State's professed intent to protect maternal health, but Tennessee's roster of abortion regulations also reveals its true legislative priorities. That is, even setting aside the Delay Law, Tennessee already has some of the most restrictive anti-abortion laws in the country.[31] Although some of these laws have survived legal scrutiny on their own, Tennessee's overall pattern of burdening abortion in any way possible shows its true intent. Specifically, Tennessee has passed abortion restrictions that include:

- A law that acts as a near-total abortion ban by criminalizing abortion if a fetal "heartbeat" can be detected (which is often only 6 weeks after a person's last period, before many know they are pregnant). Tenn. Code Ann. § 39-15-216.
- A ban on abortions after viability absent a written certification from the physician that the abortion is necessary to prevent "death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman" (with no exception for rape or incest). Tenn. Code Ann. §§ 39-15-211(b)(4).
- A ban on the use of state funds – and also private medical insurance – for abortion. 2010 Tenn. Pub. Acts, ch. 879 (enacted May 11, 2010).
- A ban on the use of telehealth for medication abortion. Tenn. Code Ann. § 63-6 241.

[31] *See Tennessee*, Evaluating Priorities, https://evaluatingpriorities.org/ (last accessed April 8, 2021).

- A requirement that the clinician display and narrate an ultrasound to the abortion patient, even if the pregnancy is nonviable or the result of rape or incest. 2020 Tenn. Pub. Acts, ch. 764; Tenn. Code Ann. § 9-4-5116; Tenn. Code Ann. § 56-26-134.

Further demonstrating the State's active animus towards reproductive autonomy and disregard for a woman's self-determination, in 2014 Tennessee passed a law – Tenn. S.B. 1391 – allowing pregnant people to be arrested for using narcotics during pregnancy. This law provided for up to *15 years of incarceration and loss of child custody* if the drug use resulted in the child being born exposed to or harmed by the drug. Despite strong opposition on local, national, and international levels, this law remained in effect until July 2016. During that time, more than 100 women were arrested under it across the state.[32]

In the past year, Tennessee has made its intention of burdening abortion to the point of banning abortion even more stark. In April 2020, Governor Bill Lee used the COVID-19 public health emergency to issue an order banning all "non-essential" medical procedures, including abortions.[33] This Court affirmed a preliminary injunction granted by the Middle District of Tennessee that limited Governor Lee's

[32] Nina Liss-Schultz, *Tennessee's War on Women Is Sending New Mothers to Jail*, Mother Jones, (Mar. 14, 2016), https://www.motherjones.com/politics/2016/03/tennessee-drug-use-pregnancy-fetal-assault-murder-jail-prison-prosecution/.

[33] Governor Lee, Executive Order 25 (Apr. 8, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee25.pdf (last visited April 8, 2020).

order, finding that every "serious medical or public health organization" opposed the order.[34]

The result of these intensely restrictive policies and hostility from lawmakers is that it is nearly impossible for Tennessee providers to continue offering abortion care to their patients. Only eight outpatient clinics currently provide abortion care in Tennessee, leaving 96% of counties in Tennessee with no clinics that provide abortion care.[35] The Delay Law compounds the problems created by this limited access to abortion care, presenting a substantial obstacle to people seeking abortion, particularly for BIPOC and low-income women, as discussed in the next section.

II. Tennessee's Delay Law Presents Substantial Obstacles For Already Disproportionately-Burdened People.

Even if the State's legislative justification were genuine, the Delay Law would still be unconstitutional under "based on the district court's unchallenged findings of fact, . . . with or without balancing," because it substantially burdens the exercise of Tennesseans' right to abortion. Order, Dkt. No. 38-2 at 11 (Feb. 19, 2021). That is, the Delay Law poses "an undue burden under *Casey*," *id.*, substantially burdening, among others, low-income people, many of whom are BIPOC.

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[34] *Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 926 (6th Cir. 2020) *vacated as moot*, No. 20-482, 2021 WL 231544 (U.S. Jan. 25, 2021).

[35] *See* Guttmacher Institute, *State Facts About Abortion: Tennessee*, Sept. 2020, https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-tennessee (last visited April 8, 2021).

A. The Delay Law Substantially Burdens Low-Income People.

The Delay Law creates a substantial burden for low-income people. For all the reasons described above, *see supra* I.B, and as the district court noted, "[a]bortion is more common among women with lower incomes." *Adams & Boyle,* 2020 WL 6063778, at *11 (internal quotation marks omitted). Specifically, the district court highlighted "fully credible" testimony that, at one clinic in Tennessee, "the majority of . . . patients have lower incomes, with 80% of its patients qualifying for financial assistance." *Id.*, at *18. Further, "75% of women seeking abortions are poor or low income, i.e., with incomes under 200% of the federal poverty guideline, and . . . the overwhelming majority of women seeking an abortion in Tennessee are already mothers and are either poor or near low-income." *Id.*, at *34 (internal quotation marks omitted).

Paradoxically – but not coincidentally[36] – the Delay Law makes accessing abortion care disproportionally difficult for *these same people* who tend to need it most. That is, as the district court found, the Delay Law "imposes various burdens on low-income women that substantially limit their access to abortion or prevent them from accessing this service altogether." *Id.*, at *34. The Supreme Court has held, repeatedly and recently, that these burdens a person experiences while

[36] *See supra* Section I.D.

obtaining an abortion matter under *Casey*. *See June Med. Servs.*, 140 S. Ct. at 2120, 2128–30, 2132–23; *Whole Woman's Health*, 136 S. Ct. at 2309, 2310–13, 2316–18.

1. The Delay Law Makes Abortion Care Much More Expensive – Often Prohibitively So.

The Delay Law greatly increases the cost of abortion care, such that it makes the cost prohibitive for many people. Most basically, the Delay Law means the medical and travel expenses for abortion care are "at least doubl[ed]." *Adams & Boyle*, 2020 WL 6063778, at *63. Even when patients were only required to attend one medical appointment, "[i]ndividual financial . . . barriers, including difficulties in raising the funds for the procedure . . . have been well documented."[37] However, the Delay Law is particularly "devastating for low-income patients because it requires them to travel to a clinic for a second appointment, thereby at least doubling [their] costs," such as childcare, transportation costs, gas, hotel stays, and food. *Adams & Boyle,* 2020 WL 6063778, at *63. "These additional expenses . . . place abortion beyond the reach of many low-income patients." *Id.*[38]

The Delay Law also adds to the cost of abortion because it forces patients to obtain care at a later gestational age. Because clinics often do not have another

[37] Jerman et al., *supra* note 21.

[38] *See also* Kari White, et al., *Travel for Abortion Services in Alabama and Delays Obtaining Care*, 27-5 Women's Health Issues, 523 (Apr. 7, 2017), https://www.sciencedirect.com/science/article/abs/pii/S1049386716302882.

appointment immediately available 48 hours after a patient's first visit, the Delay Law means that abortions will happen later in any given pregnancy. But "the cost of abortion rises with gestational age," and abortions performed after a gestational age of 20 weeks can be up to *three times as expensive* as those done earlier.[39] In fact, the district court found that the Delay Law has already had the effect of pushing more patients to have second trimester abortions, which are "not only riskier, particularly for patients with certain medical conditions, but they are also longer, more painful, riskier and more expensive than earlier abortions." *Adams & Boyle*, 2020 WL 6063778, at *29. Unsurprisingly, due to the increased costs of abortions later in pregnancy, "[i]ndividuals living in . . . states without Medicaid coverage of abortion [like Tennessee] [are] more likely than those in Medicaid coverage states to report having to gather money to pay for travel expenses or the abortion as a barrier to abortion care."[40]

The long-term consequences of placing abortion care beyond the reach of low-income patients can be dire. People who are unable to get "an abortion [are] three

[39] *Abortion After the First Trimester in the United States*, Planned Parenthood, https://www.plannedparenthood.org/uploads/filer_public /99/41/9941f2a9-7738-4a8b-95f6-5680e59a45ac/pp_abortion_after_the_first_ trimester.pdf.

[40] Ushma D. Upadhyay et al., *State abortion policies and Medicaid coverage of abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: A national cohort study*, 274 Social Science & Medicine (2021), https://www.sciencedirect.com/science/article/pii/S0277953621000794.

times more likely to end up below the federal poverty line two years later. In contrast, ensuring abortion access enabled [patients] to achieve aspirational goals related to education, employment, and change in residence."[41] Further, even those who succeed in "cover[ing] the expenses for a second appointment put themselves, and their families, at risk by spending money in this way, as many will go without basic necessities, take out predatory loans, or borrow money from abusive partners or ex-partners." *Adams & Boyle*, 2020 WL 6063778, at *63.

Because the Delay Law's mandatory 48-hour waiting period has been in effect since 2015, enough time has passed that its particular effects have been scientifically studied, and the conclusions are damning. A September 2020 study of the Delay Law's effects found that "the introduction of the mandatory waiting period caused a 48–73[%] increase in the share of abortions obtained during the second trimester" and caused an increase in the expense of obtaining an abortion "*by up to $929*."[42] As noted earlier, the maximum government assistance amount for a family of three in

[41] Ibis Reproductive Health, *Research Brief: The impact of out-of-pocket costs on abortion care access*, at 3 (Sept. 2016) https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Brief%20OutOfPocket%20Impact.pdf (last visited April 8, 2021).

[42] Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*, NBER Working Paper No. 26228, at 36 (Sept. 2020), https://www.nber.org/papers/w26228 (emphasis added).

Tennessee is *$185 per month*.[43] The increase in the cost of abortion care presents an insurmountable burden for many people in Tennessee.

2. The Delay Law Increases the Logistical Burdens of Abortion Care.

The Delay Law also substantially increases the logistical burdens on patients seeking abortion care, particularly those with low incomes. "[L]ow-income women have difficulty attending two appointments" because of logistical issues, such as missing or being fired from work, needing to arrange childcare, and having difficulty arranging or paying for the necessary travel itself. *Adams & Boyle*, 2020 WL 6063778, at *28 (internal citations and quotation marks omitted).

First, while many people take sick leave for granted, low-income workers are less able to take medical leave than higher-income workers because of concern over lost wages or fear of losing their job entirely. This is particularly true for people working hourly, temporary, or non-salaried jobs. In the U.S., 71% of low-income workers *did not* have paid vacation days, sick leave, or personal time off available to them.[44] In fact, lower-income workers were twice as likely as those with higher-incomes to report that in the past two years they wanted or needed to take medical

[43] *See* Goehring et al., *supra* note 20.

[44] *Id.*

leave but were unable to do so.[45] A full 65% of lower-income workers who did not take leave when needed said that they would have risked losing their job if they had taken the time off.[46]

Second, as the district court found, the Delay Law doubles the childcare needed while someone is seeking abortion care, and this added burden is particularly challenging for low-income people. Specifically, the district court held that "[t]he evidence demonstrates conclusively that patients face significant financial barriers to accessing care because the [Delay Law's] waiting period requires patients to visit a clinic twice and to therefore pay twice for travel *and (for the two-thirds of patients who have at least one child already) childcare*." *Adams & Boyle*, 2020 WL 6063778, at *62 (emphasis added).

Third, physical transportation issues impose an additional burden on seeking abortion care, particularly for low-income patients who may not own a car or otherwise easily arrange for transportation. As the district court noted, "the geographic distribution of the eight abortion providers in just four cities in Tennessee makes it difficult for patients to attend even one appointment," let alone two. *Id.*, at

[45] Nikki Graf, *Why workers don't always take family or medical leave when they need to*, PEW Research (Apr. 4, 2017), https://www.pewresearch.org/fact-tank/2017/04/04/why-workers-dont-always-take-family-or-medical-leave-when-they-need-to/.

[46] *Id.*

*28. The Delay Law therefore particularly burdens low-income people living in rural areas, "who often have to travel for many hours to reach a health care practitioner."[47]

B. The Delay Law Disproportionately Burdens BIPOC, Including Black and Latina Women.

Because the Delay Law substantially burdens abortion care access for low-income people, the burdens especially affect BIPOC – particularly Black and Latino or Hispanic Tennesseans – since in Tennessee 25% of Black women and 30% of Latina women live in poverty, compared with 14.8% of white women.[48] Studies indicate that despite possessing the same level of education, experience, and skills, Black and Latina women in Tennessee typically earn 68 cents and 54 cents, respectively, for every dollar paid to a white man.[49] Black women and other women of color disproportionately rely on abortion care as well: in Tennessee, 50% of abortion patients are Black,[50] despite the fact that Black people only make up 17%

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[47] American College of Obstetricians and Gynecologists, *Increasing Access to Abortion*, Committee on Health Care for Underserved Women, Opinion No. 815 (Nov. 2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion.

[48] *Status of Women in the States*, Tennessee Fact Sheet, IWPR #R523, (Mar. 2018), https://statusofwomendata.org/wpcontent/themes/witsfull/factsheets/economics/factsheet-tennessee.pdf.

[49] *See Tennessee: State by State*, National Women's Law Center, July 21, 2020, https://nwlc.org/state/tennessee/.

[50] *See Status of Women in the States*, *supra* note 48; *Reported Legal Abortions by Race of Women Who Obtained Abortion by the State of Occurrence*, Kaiser Family Foundation, https://www.kff.org/womens-health-policy/state-indicator/abortions-

of Tennessee's population.[51] The Delay Law also disproportionately burdens BIPOC because "[p]eople of color seeking abortions may have to drive through places where they will be targeted by police and immigration enforcement en route to their abortion care."[52]

C. Medically Unnecessary Restrictions Like the Delay Law Cause Stigmatic Harm, Adding to the Burden of Seeking Abortions.

As federal courts recognize, stigma can impose an undue burden on abortion access. *See, e.g.*, *Little Rock Fam. Plan. Servs. v. Rutledge*, 398 F. Supp. 3d 330, 415 (E.D. Ark. 2019) ("harassment and stigma" faced by abortion providers was part of undue burden caused by regulation); *Whole Woman's Health v. Smith*, 338 F. Supp. 3d 606, 636 (W.D. Tex. 2018) ("increased grief, stigma, shame, and distress" caused by Texas fetal tissue disposal regulations "burdens those women whose beliefs differ from the viewpoint of the State [and] . . . imposes intrusive and heavy burdens upon . . . a woman's right to choose to have an abortion"); *Hopkins v. Jegley*, No. 4:17-cv-404-KGB, 2021 WL 41927, at *87 (E.D. Ark. Jan. 5, 2021) ("fear of harassment

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by-race/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed April 8, 2021).

[51] *Quick Facts, Tennessee*, Census.Gov, https://www.census.gov/quickfacts/TN (last accessed April 8, 2021).

[52] Amy Reed-Sandoval, *Travel for Abortion as a Form of Migration*, Essays in Philosophy (Feb. 21, 2021), https://www.pdcnet.org/collection/fshow?id=eip_2021_0999_2_23_6&pdfname=03%20Amy%20Reed-Sandoval.pdf&file_type=pdf.

and stigma" resulting from Arkansas statute that would have shared medical records including on abortion care "would further interfere with a woman's right to decide to end a pregnancy").

The Delay Law causes stigmatic harm because there is no medical basis for a mandatory waiting period prior to administering abortion care.[53] Instead, as the district court correctly found, "the mandatory waiting period is . . . gratuitously demeaning to women who have decided to have an abortion." *Adams & Boyle*, 2020 WL 6063778, at *63. "[T]he waiting period—*which Tennessee does not apply to any medical procedures men may undergo*—demeans women by implicitly questioning their decision-making ability." *Id.* (emphasis added). And it "reinforces and perpetuates the stigmatizing stereotype that women are overly emotional and incapable of making rational decisions and must therefore be given an arbitrary 'time out' or 'cooling off period' to further consider the gravity of their situations." *Id.*

This stereotype is – obviously – false. At the risk of dignifying this assertion with a full response, "the vast majority of women who attended the initial consultation visit did return for their procedure" despite the waiting period, and the

[53] Theodore J. Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review*, Guttmacher Institute, 2009, https://www.guttmacher.org/report/impact-state-mandatory-counseling-and-waiting-period-laws-abortion-literature-review.

evidence suggests that those who did not return only did so because of financial or other logistical barriers[54] – *not* because they had changed their mind.

Suggestions that women cannot be trusted to make their own decisions about what is best for their health and their families are harmful and dangerous. The Delay Law also reinforces supposedly benevolent sexist stereotypes of women as mothers, by signaling that women seeking an abortion are deviating from the nurturing role for which women are suited. Research shows that such stereotypes are extremely difficult to undo once they are in place and can do lasting damage, and this is particularly true for Black women, who already face significant societal stigma based on their multiple, intersecting identities.[55] The power of the state should not be reinforcing these outdated and false tropes.

Aside from reinforcing harmful stereotypes, the Delay Law also reinforces the stigma associated with abortion itself. "Legal restrictions [such as] . . . waiting periods . . . in the United States make it more difficult for women to obtain abortions and reinforce the notion that abortion is morally wrong."[56] "[O]ne woman, who

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[54] *See* White, et al., *supra* note 38.

[55] *Cf.* Mary Beard, *The Public Voice of Women*, 36(6) London Review of Books, 11–14 (2014); Jonathan Feingold, *Racing Towards Color-blindness: Stereotype Threat and the Myth of Meritocracy*, Geo. J. of L. and Modern Critical Race Perspectives 231 (2011), https://scholarship.law.bu.edu/faculty_scholarship/826.

[56] Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 Women's Health Issues S49 (2011),

traveled 85 miles from Indiana to Michigan, said that the experience of having to cross state lines itself was distressing and further stigmatized the experience."[57] Perpetuation of this stigmatic harm is the antithesis of the underlying aim of reproductive justice: furthering the human rights to dignity, self-determination, and autonomy.

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The Tennessee politicians who passed the Delay Law have shown they are not interested in understanding the experiences of those who are most affected and know what is best for their families and communities.[58] If they were, they would learn that – for all the reasons stated above – the Delay Law gravely harms women and other people seeking abortions in Tennessee, including those who are already most vulnerable or in need.

CONCLUSION

https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/AbortionStigma.pdf.

[57] Jerman et al., *supra* note 21 ("It just makes you feel like you're doing something bad. You know, like you're going out of state because where you live doesn't allow it. It just makes you feel kind of guilty for no reason.").

[58] *See Tennessee Legislators Try to Silence Cherisse Scott*, Now This (August 19, 2019, at 6:PM), https:// nowthisnews.com/videos/news/tennessee-legislators-try-to-silence-cherisse-scott.

This Court should affirm the district court's decision to permanently enjoin Tenn. Code Ann. § 39-15-202(a)–(h).

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the appellate CM/ECF system on April 8, 2021.

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