No. 17-50282

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PLANNED PARENTHOOD OF GREATER TEXAS FAMILY PLANNING AND PREVENTATIVE HEALTH SERVICES, INC., PLANNED PARENTHOOD SAN ANTONIO; PLANNED PARENTHOOD CAMERON COUNTY; PLANNED PARENTHOOD GULF COAST, INC; PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER; JANE DOE #1; JANE DOE #2; JANE DOE #4; JANE DOE #7; JANE DOE #9; JANE DOE #10; JANE DOE #11,

Plaintiffs-Appellees

v.

CHARLES SMITH, in his official capacity as Executive Commissioner of HHSC; SYLVIA HERNANDEZ KAUFFMAN, in her official capacity as Acting Inspector General of HHSC,

Defendants-Appellants.

On Appeal from the United States District Court for the Western District of Texas, Austin Division, No. 1:15-CV-1058

BRIEF OF *AMICI CURIAE* BLACK MAMAS MATTER ALLIANCE, THE AFIYA CENTER, BLACK WOMEN'S HEALTH IMPERATIVE, THE NATIONAL BIRTH EQUITY COLLABORATIVE, SISTERSONG: THE NATIONAL WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, AND WOMEN WITH A VISION IN SUPPORT OF PLAINTIFFS-APPELLEES

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STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

Amici are the Black Mamas Matter Alliance ("BMMA") and five local and national organizations dedicated to ensuring that Black people have the rights, respect and resources they need to thrive—before, during, and after pregnancy. BMMA is a cross-sectoral, national alliance led by Black women that aims to advance maternal health, rights, and justice while eliminating racial disparities in reproductive health outcomes. BMMA and the other *amici* engage in advocacy, education, and research that promotes *reproductive justice*. As reproductive justice advocates, *amici* work in and with communities of color to protect the human rights of marginalized people in the areas of sexuality, reproduction, and bodily autonomy. Based on this expertise, *amici* have a significant interest in this case and recognize that the reproductive health services provided by Planned Parenthood are critical to the health, well-being, and self-determination of Black women and their families. *Amici* submit this brief in support of Plaintiffs-Appellees to inform the Court about the devastating and unnecessary harms that denying Medicaid patients access to Planned Parenthood's services would cause to Black women and their families in Texas.

Amici are identified individually in the annexed Appendix.

Amici have authorized undersigned counsel to file this brief on their behalf in support of Plaintiffs-Appellees. Undersigned counsel authored this brief, and no

other person or entity has funded its preparation or submission. *See* Fed. R. App. P. 29(c)(5). Counsel for all parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2).

SUPPLEMENTAL STATEMENT OF INTERESTED PARTIES

Amici listed above are the only additional interested parties beyond those listed in the parties' certificates of interested parties.

SUMMARY OF ARGUMENT

This case considers a Texas measure that would bar individuals insured by Medicaid from accessing critical and comprehensive reproductive health care services through Planned Parenthood. For many Black women in Texas, Planned Parenthood and Medicaid are crucial safety net resources that help to address racial disparities in maternal health outcomes. Because Black women in the United States have been systematically denied access to the resources and opportunities that support healthy pregnancies, maternal deaths occur nearly four times more often among Black women than among white women. This disparity has startled international observers and human rights experts, who have repeatedly expressed concern over the rising U.S. maternal mortality rate and the racial inequalities

driving it. Although preventable maternal deaths occur nationwide, Texas's maternal mortality rate has reached levels exceeding any other U.S. state.[1]

The right to make decisions about one's own body; to decide if, when, and how to have children; to choose whether to end or continue a pregnancy; to have an equal opportunity to survive pregnancy and childbirth; to parent one's existing children; and to pursue each of these rights free from discrimination and coercion are core elements of the reproductive justice framework. They are also protected by international human rights law. The international community recognizes that preventable maternal deaths often reflect a failure to address laws and policies that undermine maternal health, and human rights experts have called upon the United States to address its rising, racially disparate maternal mortality rate, and ensure that Black women have adequate access to reproductive health services.

Planned Parenthood plays a crucial role in expanding access to services that support healthy maternal outcomes, particularly for low-income women and women of color. Denying Medicaid patients access to this comprehensive health care provider disproportionately harms Black women and women of color, who face significant barriers to accessing care that can improve maternal health outcomes.

[1] Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstet. & Gynecol 1, 6 (2016).

Texas's own history cautions against this attack on Planned Parenthood. In the two years following policy changes that excluded trusted health care providers from family planning funding and cut remaining funds, health disparities in the state worsened: maternal deaths doubled, and women in Texas experienced precipitous declines in access to reproductive health services.

Barring patients on Medicaid from accessing the comprehensive services offered by Planned Parenthood exacerbates immense gaps in Texas's reproductive health safety net and undermines efforts to improve maternal health. Indeed, Texas's own Maternal Mortality and Morbidity Task Force report recommends *increasing* health care access for women of reproductive age. By barring Medicaid patients' access to Planned Parenthood, Texas instead has pursued actions that deny patients access to the very clinics that safeguard their maternal health.

ARGUMENT

I. THE UNITED STATES IS FACING A HUMAN RIGHTS CRISIS IN MATERNAL HEALTH AND BLACK WOMEN IN TEXAS ARE DISPROPORTIONATELY IMPACTED.

For decades, the United States has failed to ensure that pregnant, birthing, and postpartum individuals have an equal and adequate chance at survival. As the rest of the world takes steps to improve maternal health, the United States is moving in the

opposite and wrong direction.[2] Women in the United States suffer preventable maternal deaths at ever increasing rates, and Black women in the United States are among those most likely to die.[3] Black women in Texas are at the center of this national crisis, as maternal deaths in the state reach alarming numbers and disproportionately claim Black lives.[4] Responding to these trends, international human rights experts have repeatedly called on the United States to address the root causes of maternal deaths and health disparities.

A. The United States Has the Worst Maternal Health Outcomes in the Industrialized World.

Poor maternal health outcomes have far-reaching and often devastating consequences for women, pregnant and birthing people, their families, and their communities. As indicators of a society's overall health and well-being, maternal health outcomes also speak to whether government commitments to safeguard

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[2] *See* World Health Organization et al., *Trends in Maternal Mortality: 1990-2015*, 70-77, (2015), http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf [hereinafter World Health Organization].

[3] Ctr. for Disease Ctrl. & Prev., *Pregnancy Mortality Surveillance System*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html [hereinafter *Pregnancy Mortality Surveillance System*].

[4] Maternal Mortality and Morbidity Task Force & Tex. Dep't of State Health Servs., Joint Biennial Report, 5 (July 2016), https://www.dshs.texas.gov/mch/pdf/2016BiennialReport.pdf [hereinafter Tex. Maternal Mortality Task Force Report].

women's and children's health are serious and effective.[5] Public health experts around the world monitor the prevalence of maternal deaths using a maternal mortality ratio (MMR), which represents the number of women who die from pregnancy-related causes for every 100,000 live births.[6] Pregnancy complications that result in maternal illness, injury, or disability are referred to as maternal morbidity,[7] while life-threatening pregnancy complications, such as aneurysm and renal failure, are categorized as severe maternal morbidity.[8]

The United States ranks poorly on all these measures, with the *highest* maternal mortality ratio in the industrialized world,[9] and incidents of maternal

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[5] For instance, the Millennium Development Goals and Sustainable Development Goals use maternal mortality ratios as a benchmark for measuring progress on development. *See* Nicholas J. Kassebaum, et al., *Global, Regional, and National Levels of Maternal Mortality, 1990-2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 388 The Lancet 1775, 1775-76 (2016), http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31470-2.pdf [hereinafter The Lancet, GBD].

[6] World Health Organization, *supra* note 2, at 1.

[7] Tabassum Firoz, et al., *Measuring Maternal Health: Focus on Maternal Morbidity*, Bulletin of the World Health Organization 91, 794-796 (2013), http://www.who.int/bulletin/volumes/91/10/13-117564/en/

[8] Ctr. for Disease Ctrl. & Prev., *Reproductive Health: Severe Maternal Morbidity in the United States*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last updated May 22, 2017) [hereinafter *Reproductive Health*].

[9] Among Organisation for Economic Co-operation and Development (OECD) members—countries with "advanced" and "emerging" economies—the United States has a higher maternal mortality ratio than any country except Mexico (which is considered an emerging economy). *See* The Lancet, GBD, *supra* note 5, at 1784-93.

morbidity on the rise.[10] According to the Centers for Disease Control and Prevention (CDC), approximately 700 women in the United States die each year from pregnancy or childbirth-related causes,[11] and nearly 60 percent of these maternal deaths are preventable.[12]

In addition, more than 50,000 women in the United States nearly die from severe maternal morbidity each year.[13] The number of women experiencing near-fatal pregnancy complications has grown over the last few decades, with hospitalizations due to severe delivery complications more than doubling between 1993 and 2014.[14] For every woman who dies as a result of her pregnancy, approximately 100 women in the United States receive a life-threatening diagnosis or undergo a life-saving procedure during their delivery hospitalization.[15]

The relatively high proportion of maternal deaths in the United States—a

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[10] Andreea A. Creanga et al., *Maternal Mortality and Morbidity in the United States: Where Are We Now?*, 23 J. Women's Health, 6 (2014).

[11] Ctr. for Disease Ctrl. & Prev., *Pregnancy-Related Deaths*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.

[12] CDC Found., Report from Maternal Mortality Review Committees: A View into Their Critical Role, 23 (2017), https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf.

[13] *Reproductive Health*, *supra* note 8.

[14] *Id.*

[15] William A. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 Obstet. & Gynecol. 1029, 1034 (2012).

high-income country with advanced medical capabilities—is alarming. A global assessment of maternal mortality trends published by the World Health Organization in 2015 ranked the United States forty-sixth in the world in maternal mortality.[16] An analysis of global maternal mortality published in the journal *The Lancet* that same year assigned the United States an MMR of 26.4.[17] This places the United States well behind other wealthy countries like Finland (3.8), Australia (5.5), and Japan (6.4), as well as after poorer countries like Turkmenistan (19.4), Iran (20.8), and Libya (22.8).[18]

And while most other countries have made steady progress when it comes to maternal health and survival, the United States is one of only thirteen countries in the world—and the only developed nation—where maternal mortality is rising.[19] In fact, between 2000 and 2015, while global maternal mortality fell by more than a third, the United States' MMR *rose* more than 50% during the same period.[20]

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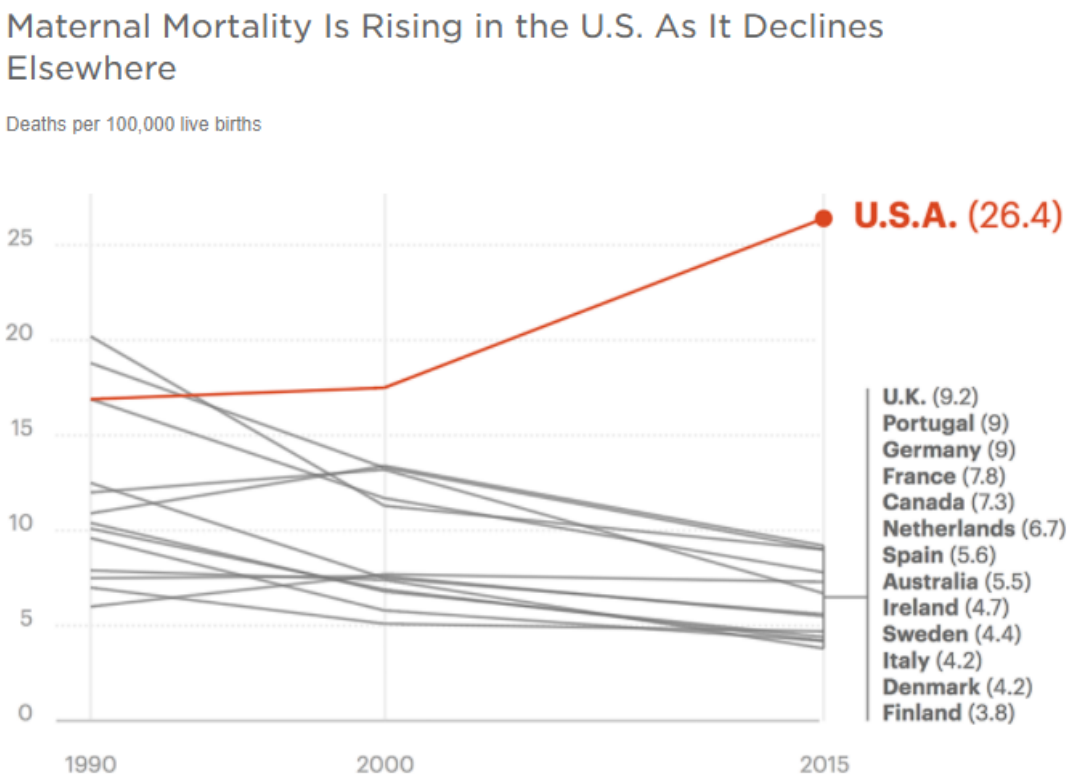
[16] *See* World Health Organization, *supra* note 2, at 51-56.

[17] The Lancet GBD, *supra* note 5, at 1784.

[18] *See id.* at 1784, 1787, 1789 and 1790.

[19] *See* World Health Organization, *supra* note 2, at 70-77.

[20] The Lancet, GBD, *supra* note 5, at 1784. *See also* MacDorman, *supra* note 1, at 1 (estimating a more modest 26.6% rise in MMR from 2000 to 2014).



As the chart above illustrates, the United States has become a notable outlier when it comes to global progress on maternal health.[21]

B. Black Women in the United States Face Heightened Risks for Poor Maternal Health Outcomes, Especially in Texas.

Black women disproportionately bear the real-life impacts of the United States' poor maternal health outcomes. Black women who give birth in the United States are nearly four times more likely to die than white women are,[22] and twice as

[21] Nina Martin, ProPublica, *Focus on Infants During Childbirth Leaves U.S. Moms in Danger*, http://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-momn-danger (data sourced from The Lancet, GBD, *supra* note 5, at 1784-93).

[22] *Pregnancy Mortality Surveillance System*, *supra* note 3.

likely to suffer from severe maternal morbidity.[23] Black women in Texas are at the center of this national crisis. With a maternal mortality ratio of more than 30 deaths per 100,000 live births, the state of Texas ranks worse than any nation in the industrialized world.[24] Black women make up almost 30% of these maternal deaths, despite the fact that only 11.4% of all births in Texas involve babies born to Black women.[25] Black women in Texas also have the highest rate of hospitalization for hemorrhage and blood transfusion, which are the most common incidents of severe maternal morbidity in Texas.[26]

The root causes of maternal mortality and morbidity are multiple and complex, but systemic forces play a substantial role.[27] Social, political, and economic conditions influence people's risk of poor health, as well as the systems put in place to prevent or treat health problems. Unequal access to quality health

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[23] Andreea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 Amer. J. Obstet. & Gynecol. 435, 437 (2014).

[24] *See* The Lancet, GBD, *supra* note 5, at 1784-93.

[25] Tex. Maternal Mortality Task Force Report, *supra* note 4, at 5.

[26] *Id.* at 11, 12.

[27] Ctr. for Reprod. Rights, Black Mamas Matter, *A State Policy Framework for the Right to Safe and Respectful Maternal Health Care*, https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_PolicyBrief_Final_5.16.pdf [hereinafter *State Policy Framework*]; *see also, e.g.*, Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 Contraception 189, 190 (2011).

care, higher rates of poverty, exposure to racism, and social inequality all undermine health[28] and explain in part the disparities in maternal health outcomes between Black women and white women in the United States.[29]

For instance, Black women face formidable economic barriers that increase their risk factors for poor maternal health outcomes. The Black/white disparity in maternal mortality applies across all education levels and persists even after controlling for differences in socio-economic status.[30] But poverty is also associated with higher rates of maternal mortality and morbidity,[31] and in the United States, Black women are more than twice as likely as white women to live in poverty.[32] Systemic economic inequalities have left a quarter of all adult Black women living

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[28] Office of Disease Prev. & Health Promotion, Healthy People, *Social Determinants of Health*, http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health.

[29] *See, e.g.*, New York City Dep't of Health & Mental Hygiene, Bureau of Maternal, Infant & Reprod. Health, *Pregnancy-Associated Mortality: New York City, 2006-2010*, 9 (2015), https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf.

[30] *See* Priya Agrawal, Health Affairs, *Same Care No Matter Where She Gives Birth: Addressing Variation in Obstetric Care through Standardization* (Sept. 12, 2014); Gopal K. Singh, U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Maternal & Child Health Bureau., *Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist* 3 (2010), https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf.

[31] *See* Singh*, supra* note 28.

[32] *See* Nat'l Women's Law Ctr., Poverty & Family Supports, *National Snapshot: Poverty Among Women & Families, 2014* (Sept. 2015), http://nwlc.org/wp-content/uploads/2015/08/povertysnapshot2014.pdf (poverty rate in 2014 for adult Black women in 2014 was 25% and 10.8% for white women).

beneath the federal poverty threshold.[33] In addition, the South is the poorest region in the country,[34] and 23.6% of Black women in Texas live in poverty.[35]

Similarly, women of color across the United States are more likely than white women to lack health insurance,[36] and Southern states are among the worst in the country for coverage for Black women.[37] Many fall into the coverage gap left by the primarily Southern states that have not expanded Medicaid, including Texas.[38]

Black women also experience disproportionately poor outcomes on a range of sexual and reproductive health measures that negatively impact pregnancy and birth. For example, Black women die from cervical cancer at twice the rate of white women.[39] Although African Americans make up only 12% of the United States'

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[33] *Id.*

[34] Carmen Denavas-Walt & Bernadette Proctor, U.S. Census Bureau, *Income and Poverty in the United States: 2014* at 15 (Sept. 2015), http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf.

[35] Nat'l Women's Law Ctr., *Poverty Rates by State, 2012* (Sept. 2013), http://www.nwlc.org/sites/default/files/pdfs/final_compiled_state_poverty_table_2012.pdf.

[36] Algernon Austin, Ctr. for Global Pol'y Solutions, *Obamacare Reduces Racial Disparities in Health Coverage* 6-7 (Dec. 2015), http://globalpolicysolutions.org/wp-content/uploads/2015/12/ACA-and-Racial-Disparities.pdf.

[37] Avis Jones-DeWeever, Nat'l Coal. on Black Civic Participation, Black Women's Roundtable, *2015 Black Women and Health from Black Women in the U.*S. 11 (2015), http://ncbcp.org/news/releases/BWRReport.BlackWomeninU.S.2015.3.26.15FINAL.pdf.

[38] Kaiser Fam. Found., *Who is Impacted by the Coverage Gap in States that Have Not Adopted Medicaid Expansion?* (Nov. 2016), http://kff.org/slideshow/who-is-impacted-by-the-coverage-gap-in-states-that-have-not-adopted-the-medicaid-expansion/.

[39] Ctr. for Disease Ctrl. & Prev., *Cervical Cancer Rates by Race and Ethnicity* (June 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm.

population, they account for 44% of new HIV infections and almost half of HIV-related deaths.[40] As public health research recognizes, racism and sexism can delay access to STI counseling, screening, and early access to treatment, with young Black women facing substantial barriers.[41] These STI disparities carry significant health risks while also contributing to adverse outcomes during pregnancy.[42]

Finally, the poorest women in the United States are five times more likely than their wealthy counterparts to experience an unintended pregnancy, which raises their risk of complications and can contribute to poorer health outcomes for both mothers and their babies.[43] Southern states have particularly high rates of unintended

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[40] Ctr. for Disease Ctrl. & Prev., *HIV Among African Americans,* http://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated June 9, 2017).

[41] *See* In Our Own Voice, Nat'l Black Women's Reprod. Justice Agenda, *Our Lives Our Bodies Our Voices: The State of Black Women & Reproductive Justice*, 66 (June 27, 2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf [hereinafter In Our Own Voice].

[42] Ctr. for Disease Ctrl. & Prev., *STDs in Women and Infants* (Nov. 17, 2015), http://www.cdc.gov/std/stats14/womenandinf.htm#impactPreg.

[43] *See* Guttmacher Inst., *Unintended Pregnancy in the United States* (July 2015), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html; Denise D'Angelo et al., CDC, *Preconception Health Status of Women Who Recently Gave Birth to a Live-Born Infant – Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 26 Reporting Areas, 2004*, MMWR Surveillance Summ. (Dec. 14, 2007), http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5610a1.htm.

pregnancy; in Texas, 54% of all pregnancies are unintended.[44] Black women and girls are also significantly more likely than white women and girls to lack access to contraceptive services and sexuality education.[45] Without equal access to these critical resources, Black women have a disproportionately high rate of unintended pregnancy and are therefore more likely to enter pregnancy having missed out on the benefits of preconception care. [46]

C. International Human Rights Experts Have Expressed Concerns That Rising Maternal Mortality Rates in the United States Violate Human Rights Standards and Norms.

Preventing maternal mortality and morbidity has become a global priority, in line with the international community's understanding that poor outcomes are not inevitable, but often result from laws, policies, and institutional practices that can be

[44] Guttmacher Inst., *State Facts About Unintended Pregnancy: Texas* (Sept. 2016), https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-texas. The unintended pregnancy rate in the region is similar: 60% of all pregnancies in Louisiana and Georgia, 62% in Mississippi, 55% in Alabama, and 59% in Florida. *See* Guttmacher Inst., *State Facts About Unintended Pregnancy* (Sept. 2016) (fact sheets for Louisiana, Georgia, Mississippi, Alabama, and Florida).

[45] *See* Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1772, 1774 (2013).

[46] *See* Guttmacher Instit., *Unintended Pregnancy in the United States* (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

changed.[47] Human rights bodies have further recognized that enabling safe pregnancy and childbirth is essential to women's dignity and exercise of their human rights,[48] and international human rights experts have raised concerns that trends in the United States' maternal mortality rates violate international human rights standards.

For example, in 2014, the United Nations (UN) Committee on the Elimination of Racial Discrimination (CERD), a committee of experts that oversees countries' implementation of the International Convention on the Elimination of All Forms of Racial Discrimination,[49] called on the United States to comply with treaty

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[47] Office of the United Nations High Comm. for Human Rts., et al., *Summary Reflection Guide on a Human Rights-Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health, and Under-5 Child Health* 3 (2015), http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/RGuide_NHRInsts.pdf.

[48] *See,* e.g., Int'l Convention on the Elimination of All Forms of Racial Discrimination, Comm. on the Elimination of Racial Discrimination, Concluding Observations: United States of America, ¶ 15, U.N. Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014) [hereinafter Concluding Observations]; United Nations Comm. on the Elimination of Discrimination against Women, Comm'n No.17/2008, ¶¶ 7.5-7.6, U.N. Doc. CE-DAW/C/49/D/17/2008 (July 25, 2011). *See also* United Nations Human Rights Council, Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity (20th Sess. 2012), ¶ 8, U.N. Doc. A/HRC/21/22 (2012).

[49] The U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination in 1994, committing itself to eliminate discrimination based on race, color, ethnicity, and national origin, including in public health, medical care, and social services. G.A. Res. 2106 (XX), Annex, 20 U.N. GAOR Supp. No. 14 at 47, International Convention on the Elimination of All Forms of Racial Discrimination, U.N. Doc. A/6014 (1966) (entered into force Jan. 4, 1969).

obligations by eliminating racial disparities in health.[50] The Committee expressed specific concern over high rates of maternal mortality among Black women and recommended that the United States government take steps to ensure access to adequate and affordable health services for all.[51] In 2015, during a comprehensive peer review of its human rights record before the UN Human Rights Council, the United States received and supported a strong recommendation to "ensure equal access to quality maternal health services."[52]

Following an official United States visit in 2015 that included Texas, the UN Working Group on Discrimination Against Women in Law and Practice—a group of independent human rights experts—also recommended that the government remedy pervasive racial disparities in maternal health. The Working Group specifically urged the United States to address legacies of racism and the root causes of maternal mortality for Black women, and ensure access to sexual and reproductive health services by preventing the exclusion of women's health providers from public

[50] Concluding Observations, *supra* note 48, ¶ 15.

[51] *Id*.

[52] United Nations Human Rights Committee, Rep. of the Working Group on the Universal Periodic Review: United States, ¶ 176.316, U.N. Doc. A/HRC/30/12 (July 20, 2015).

health programs.[53] In 2016, another group of independent human rights experts, the UN Working Group of Experts on People of African Descent, likewise noted troubling racial disparities in United States' health outcomes, and called for policies that prioritize the reduction of maternal mortality for Black women.[54]

II. PLANNED PARENTHOOD PLAYS A CRUCIAL ROLE IN SAFEGUARDING MATERNAL HEALTH.

Against this backdrop of the United States' maternal health crisis, Planned Parenthood safeguards maternal health by providing a range of comprehensive health care services that enable women to enter pregnancy at a time that is safest for them, and to stay healthy before, during, and after pregnancy.

Planned Parenthood is a critical health service provider for low-income women and women of color across the country. Fifteen percent of Planned Parenthood's patients are Black women and 21% identify as Latina.[55] In addition,

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[53] United Nations Human Rights Council, Rep. of the Working Group on the Issue of Discrimination Against Women in Law and Practice on its Mission to the United States of America, ¶¶ 94(f), 95(a-f), U.N. Doc. A/HRC/32/44/Add.2 (32nd Sess., 2016), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/172/75/PDF/G1617275.pdf.

[54] United Nations Human Rights Council, Rep. of the Working Group of Experts on People of African Descent on its mission to the United States of America, ¶¶ 48, 56, 117, U.N. Doc. A/HRC/33/61/Add.2. (33rd Sess. 2016), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/183/30/PDF/G1618330.pdf.

[55] Planned Parenthood Fed. of Amer., *This is Who We Are* (2017), https://www.plannedparenthood.org/uploads/filer_public/79/bb/79bb45d5-4d6b-4ef4-833d-8ea007429267/20170526_whoweare_fs_d02.pdf.

78% of Planned Parenthood's patients have incomes at or below 150% of the federal poverty level,[56] and more than half of its health centers are in rural and underserved communities.[57]

As an essential safety-net provider for low-income women and women of color who are either uninsured or covered by Medicaid, Planned Parenthood provides crucial access to care that promotes maternal health, including critical preventive services. Indeed, Planned Parenthood may be a person's only health care provider and source for primary care, such as blood pressure testing and screening for diabetes.[58]

Planned Parenthood provides comprehensive sexual and reproductive health education to women before and during pregnancy. Access to this critical information promotes maternal health by reducing unplanned pregnancies and sexually transmitted infections (STIs)—both of which increase the possibility of pregnancy

[56] *See* George P. Topulous, et al., *Planned Parenthood at Risk*, 373 New Eng. J. of Med. 963 (2015).

[57] Planned Parenthood, *The Urgent Need for Planned Parenthood Health Centers* (2016), https://www.plannedparenthood.org/files/4014/6773/0282/20160620_Defunding_fs_d1_4.pdf.

[58] *See* Planned Parenthood, *Our Services: General Health Care*, https://www.plannedparenthood.org/get-care/our-services/general-health-care.

complications and poor maternal health outcomes.[59] For low-income Black women who are more likely than white women to lack access to comprehensive sex education,[60] Planned Parenthood is one the few resources available to address that need.

Planned Parenthood also provides women with affordable cancer and STI screenings. Such screenings can be life-saving for Black women, who are routinely diagnosed with cancer, including reproductive cancers—breast, cervical, and ovarian—at later stages, and have lower survival rates than other racial and ethnic groups.[61] Health disparities likewise exist with regard to STIs,[62] which can cause pregnancy complications and poor outcomes such as miscarriage, ectopic pregnancy, preterm labor or delivery, and stillbirth.[63] In 2015 alone, Planned Parenthood performed over 615,000 Pap tests and breast exams, and conducted over

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[59] *See* Douglas B. Kirby, *The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior*, 5 Sex. Res. Soc. Pol'y 18 (2008); *see also* Ctr. for Disease Ctrl. & Prev., *STDs During Pregnancy*, https://www.cdc.gov/std/pregnancy/stdfact-pregnancy.htm (last updated Nov. 2016) [hereinafter Kirby].

[60] *See* Risha K. Foulkes, *Abstinence-Only Education and Minority Teenagers: The Importance of Race in a Question of Constitutionality*, 10 Berkeley J. Afr.-Am. L. & Pol'y 3 (2008) (discussing impact of move toward abstinence-only education in public schools).

[61] In Our Own Voice, *supra* note 41, at 57-61.

[62] *See id*. at 65-71.

[63] *See* Kirby, *supra* note 59; Joel Coste, et al., *Sexually Transmitted Diseases as Major Causes of Ectopic Pregnancy*, 62 Fertil. Steril. 289 (1994).

4.2 million tests and treatments for STIs.[64]

In addition, Planned Parenthood provides critical and affordable access to contraception, which enables women to choose if and when to become parents, and to enter pregnancy under circumstances that are right for them. When individuals have the opportunity to time pregnancies around their physical, mental, emotional, and financial well-being, the potential for pregnancy-related complications is reduced.

Planned Parenthood's role in serving women who seek family planning services from publicly-funded health centers is extraordinary. In 2010, 36% of women who obtained contraceptive care from a safety-net center received it at a Planned Parenthood, even though Planned Parenthood only accounts for 10% of publicly-funded clinics.[65] In areas with already limited health care infrastructure, Black women often depend on entities like Planned Parenthood for essential family planning services.[66] Not only do these services play a critical role in the lives of individuals that rely on them, but the cumulative impact on public health is

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[64] Planned Parenthood Fed. of Amer., *2015-2016 Annual Report*, 22 (2016), https://www.plannedparenthood.org/uploads/filer_public/18/40/1840b04b-55d3-4c00-959d-11817023ffc8/20170526_annualreport_p02_singles.pdf [hereinafter Planned Parenthood].

[65] Guttmacher Instit., *Need, Use and Impact of Publicly Funded Family Planning Services* (Sept. 2016), https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states#4a.

[66] *State Policy Framework*, *supra* note 27, at 6.

substantial: in 2015, Planned Parenthood's contraceptive services averted an estimated 557,000 unintended pregnancies.[67]

Finally, while comprising 3% of the services that it provides, Planned Parenthood offers women access to safe abortion services, helping women to decide if and when they want to become parents or grow their families.[68] Enabling women to safely terminate their pregnancies reduces the likelihood of pregnancy complications and poor maternal health outcomes, while increasing the likelihood that these same women are able to become healthy mothers in the future, if and when they so choose.

III. DENYING ACCESS TO HEALTH PROVIDERS LIKE PLANNED PARENTHOOD PUTS MATERNAL HEALTH AT RISK.

Over the last several years, Texas has enacted changes in policy that endanger its reproductive health safety net; these changes correlated with a precipitous decline in maternal health outcomes. At a moment when Black women in Texas face what the State recognizes as increasing, unnecessary, and preventable deaths,[69] its actions to undermine reproductive health care—including through the measure at issue here—are directly counterproductive.

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[67] Planned Parenthood, *supra* note 64, at 22.

[68] *See, e.g.*, *id*. at 23.

[69] *See* Tex. Maternal Mortality Task Force Report, *supra* note 4, at 5; *see also* Maternal Mortality and Morbidity Task Force & Tex. Dep't of State Health Servs., Joint Biennial Report, 2 (Sept. 2014), https://www.dshs.texas.gov/mch/pdf/2014-Legislative-Report.pdf.

A. Texas's Policies Have Sharply Curtailed Its Residents' Access to Reproductive and Family Planning Health Care Providers and Disproportionately Impacted Access for Women of Color.

Beginning in 2011, Texas took several actions that gutted its reproductive health safety net. After implementing a family planning expansion project under Medicaid that, according to the State's own data, improved access to contraception, reduced unintended pregnancies, and lowered the number of Medicaid-funded births,[70] Texas changed course and applied for a waiver to exclude abortion providers and affiliates from this project.[71] The federal government denied the waiver, finding, among other things, that it "would eliminate Medicaid beneficiaries' ability to receive family planning services from specific providers for reasons not related to their qualifications to provide such services."[72] The State then chose to run its family planning program entirely with state dollars, and excluded from that program "many of the very safety-net providers most able to provide high-quality

[70] *See generally* Tex. Health & Human Servs. Comm'n, *2010 Annual Savings and Performance Report for the Women's Health Program* (2011), https://hhs.texas.gov/reports/2011/08/rider-64-annual-savings-and-performance-report-womens-health-program.

[71] *See* Letter from Cindy Mann, Dir. Dep't. of Health & Hum. Services., Ctrs. for Medicare & Medicaid Servs., to Billy Millwee, Associate Comm'r Tex. Health & Human Servs. Comm'n (Dec. 12, 2011), http://www.lrl.state.tx.us/scanned/archive/2011/17104.pdf.

[72] *See id*.

contraceptive care to large numbers of women," including Planned Parenthood.[73] During this same period, the Texas legislature slashed family-planning grants by 66%.[74]

The impact of these policy decisions was immediate and devastating. While many were designed to target Planned Parenthood—the largest preventive reproductive health care service provider in the state—the fallout was far broader: 82 family-planning clinics in the state shut down, one-third of which were affiliated with Planned Parenthood.[75] Nearly half of the facilities that continued to receive state funding had to reduce staff, with the most severe cuts to clinics specializing in family planning services.[76]

These deep cuts to family planning funds, and to Planned Parenthood in particular, devastated women's access to family planning and other preventive services and imposed disproportionate harm on women of color. For example, a

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[73] Kinsey Hasstedt & Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, Health Affairs, (July 18, 2017), http://healthaffairs.org/blog/2017/07/18/at-it-again-texas-continues-to-undercut-access-to-reproductive-health-care/ [hereinafter *At It Again*].

[74] Amanda J. Stevenson, et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. of Med. 853, 854 (2016) [hereinafter Stevenson].

[75] *Id*.

[76] Ctr. for Reprod. Rts. & Nat'l Latina Instit. for Reprod. Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* 18 (Nov. 2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf [hereinafter *Nuestro Texas*].

2012 fact-finding mission in the Rio Grande Valley of Texas—a predominantly Latino area—documented the destructive impact these cuts had on Latinas, finding that over half of adult women of reproductive age in the area lacked health insurance, making them disproportionately reliant on safety-net health programs.[77] With such programs under attack, women living in border counties had even less access to women's health care than the general population. As one woman in the Valley described: "Planned Parenthood was a trusted and safe place where people knew they could go to get services or their checkup. Now that [Texas] cut their funds, it's like [the State] closed the door in our faces."[78]

Despite this evidence, Texas has continued to pursue these policies. As public health researchers have put it: "By excluding numerous safety-net health centers and relying primarily on private doctors, the state developed a provider network incapable of serving high volumes of family planning clients."[79]

B. Texas's Cuts to Family Planning Funding and Attempts to Bar Access to Planned Parenthood Coincided with a Startling Drop in Maternal Health Outcomes.

Far from effectuating Texas's self-professed goal of improving maternal health, Texas's cuts to family planning funding, along with its efforts to deny

[77] *See generally Nuestro Texas*, *supra* note 76.

[78] *Id.* at 24.

[79] *See At It Again*, *supra* note 73.

individuals access to Planned Parenthood and other essential health care providers, coincided with a near-doubling of the state's maternal mortality rate and increases in other poor maternal health outcomes that disproportionately harm women of color. In the decade preceding the cuts to Texas's family planning program, the State saw a moderate increase in its maternal mortality rate, from 17.7 in 2000, to 18.6 in 2010.[80] Then, in half that time, between 2010 and 2014, the State's maternal mortality rate nearly *doubled*, from 18.6 in 2010 to 35.8 in 2014.[81] This rapid decline in maternal health gave Texas a higher maternal mortality ratio than many developing countries, including Costa Rica, Grenada, Sri Lanka, and Bahrain.[82]

Consistent with the broader trends in the nation, the troubling trends in maternal health outcomes disproportionately affect women of color. In 2013, Texas established a Maternal Mortality and Morbidity Task Force to study the State's rising maternal mortality.[83] According to the State's own report, "Black women bear the greatest risk for maternal death," making up 28.8% of the maternal deaths in Texas, even though only 11.4% of births in the state were to Black women.[84] In assessing

[80] MacDorman, *supra* note 1, at 6.

[81] *Id*. at 6.

[82] The Lancet, GBD, *supra* note 5 at 1784-93.

[83] Tex. Maternal Mortality Task Force Report, *supra* note 4, at 3.

[84] *Id.* at 1, 5.

maternal morbidity, the State reported that "one trend remained obvious regardless of methodology—Black women were much more likely to experience [severe maternal morbidity] during a pregnancy-related hospitalization compared to women of other races and ethnicities."[85]

C. Evidence from Texas Demonstrates That Other Community Health Care Providers Are Not an Adequate Substitute for Planned Parenthood.

There is no substitute for Planned Parenthood's demonstrated ability to provide essential care to women in Texas, even while other health care providers, such as federally-qualified health centers (FQHCs) and state health departments, endeavor to fill in the reproductive health safety net. Texas's exclusion of Planned Parenthood from the state's family planning fund led to widespread clinic closures in 2011 and 2013, placing a great strain on the remaining clinics and limiting the State's capacity to deliver quality preventive care for Texan women. In 2012, after the first round of cuts, the State served 63% fewer women at an average cost per patient of 15% more than in 2011.[86]

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[85] *Id.* at 10.

[86] Jordan Smith, *Texas Women's Health Care: Costs More, Does Less*, Austin Chronicle (Nov. 30, 2012), http://www.austinchronicle.com/blogs/news/2012-11-30/texas-womens-health-care-costs-more-does-less/ (reporting based on documents filed with the State Health Services Council). The State's data also show a precipitous decline in contraceptive use among women enrolled in the state program. *See* Stevenson, *supra* note 74, at 856, 858 (describing more than 30% decline in pharmacy and medical claims for long-term contraceptives).

Myriad reasons explain this result. First, community health centers simply do not have the capacity to absorb the millions of patients who rely on Planned Parenthood each year. In 68% of counties with a Planned Parenthood health center, Planned Parenthood serves at least *half* of all safety-net reproductive health patients.[87] The average Planned Parenthood health center sees approximately 90% more contraceptive patients per year than the average FQHC site offering contraceptive care.[88] FQHCs in two-thirds of counties with a Planned Parenthood would have to increase capacity by between two and six fold to serve all of the female contraceptive clients who currently rely on Planned Parenthood.[89] Such dramatic ramp ups would be unsustainable, if not impossible, for many FQHCs that already strain to meet demand and struggle with staff shortages and lengthy wait times for appointments.[90]

Second, regardless of capacity, health care providers are simply not fungible. Planned Parenthood has lower average wait times for appointments and is more

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[87] Letter from Jennifer J. Frost, Principal Research Scientist, Guttmacher Institute, to Lisa Ramirez-Branum, Analyst, Congressional Budget Office (CBO), 2 (Aug. 14, 2015), https://www.guttmacher.org/sites/default/files/pdfs/pubs/guttmacher-cbo-memo-2015.pdf.

[88] Kinsey Hasstedt, *Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 67, 68 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf.

[89] *Id*.

[90] *Id*. at 70.

likely to offer evening and weekend hours, which eases obstacles women may face related to childcare, time off work, and transportation to a provider.[91] Planned Parenthood also is more likely than other health providers to help women obtain the right contraceptive method for them and to facilitate access to oral contraceptives without an additional trip to the pharmacy.[92]

Finally, women value the ability to choose providers that they trust, especially for sexual and reproductive health care. As one participant in a reproductive health story-sharing project involving Southern Black women explained, a positive relationship between patient and provider can be transformative: "I had a really good Black woman doctor . . . . I was very particular about who I was going to choose as a care provider . . . . and so [my questions were] received really warmly—I asked a billion questions, and she answered every one very patiently."[93]

Numerous anecdotal examples within the State reinforce the gravity of this situation. As one Brownsville woman lamented, when the State removed Planned Parenthood as an option, "the local clinics become more burdened, so . . . I cannot

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[91] Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 12, 12-13 (May 17, 2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2001216.pdf.

[92] *Id*. at 13.

[93] *State Policy Framework*, *supra* note 27, at 12.

go to Planned Parenthood for the service that they specialize in, so I go to the local clinic . . . [but they say] '. . . we do not have an appointment for six months [or] until next year.'"[94] In Midland, where a Planned Parenthood clinic closed in 2013, the community lost thousands of appointments a year.[95] While the clinic transferred approximately 5,000 patient records to Midland Community Healthcare Services—including 2,000 records of active patients who had been seen in the previous year—only 200 of those patients had visited Midland Community for their appointments since the Planned Parenthood closure. [96]

Even the State has acknowledged that efforts to replace Planned Parenthood have failed. Recently, for example, a crisis pregnancy center network that received seven million dollars under the mandate to serve two-thirds as many clients as Planned Parenthood within a year lost more than half of its funding after Texas concluded it "underperformed."[97] The network was simply not equipped to replace the contraceptive and other health services that women could previously seek from Planned Parenthood.

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[94] *Nuestro Texas, supra* note 76, at 23.

[95] Kate Zernike, *Cutting Planned Parenthood Would Increase Medicaid Births, C.B.O. Says*, N.Y. Times (Mar. 14, 2017), https://www.nytimes.com/2017/03/14/health/cutting-planned-parenthood-would-increase-medicaid-births-cbo-says.html.

[96] *Id.*

[97] Paul J. Weber, *Texas Slashes Underperforming Anti-Abortion Group's Contract*, Associated Press (Aug. 21, 2017), https://www.usnews.com/news/best-states/texas/articles/2017-08-21/texas-slashes-underperforming-anti-abortion-groups-contract.

Denying Medicaid patients access to Planned Parenthood negatively impacts both patient access and the provider safety net in Texas. Because of the sheer volume of patients that Planned Parenthood serves, the Texas measure at issue here will inevitably have a devastating effect on the reproductive health infrastructure, and will undoubtedly and disproportionately harm Black women and other women of color.

Amici agrees with the State's own Maternal Mortality and Morbidity Task Force: increasing health care access is essential to reversing Texas's poor maternal health outcomes for Black women. The State's current attempt to bar Medicaid patients from accessing Planned Parenthood as their preferred provider undermines this very goal.

CONCLUSION

For the foregoing reasons and for those set forth in the Brief of Plaintiffs-Appellees Planned Parenthood, the district court's preliminary injunction should be affirmed.

Dated: October 13, 2017

Respectfully submitted,

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APPENDIX

Black Mamas Matter Alliance (BMMA) is a Black women-led cross-sectoral alliance. BMMA centers Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice. BMMA envisions a world where Black mamas have the rights, respect, and resources to thrive before, during, and after pregnancy. As an alliance, BMMA aims to (1) change policy by introducing and advancing policy grounded in the human rights framework that addresses Black maternal health inequity and improves Black maternal health outcomes; (2) cultivate research by leveraging the talent and knowledge that exists in Black communities and cultivate innovative research methods to inform the policy agenda to improve Black maternal health; (3) advance care for Black mamas: explore, introduce, and enhance holistic and comprehensive approaches to Black mamas' care; and (4) shift culture by redirecting and reframing the conversation on Black maternal health and amplify the voices of Black mamas.

The Afiya Center is a non-profit Reproductive Justice organization based in North Texas. The Afiya Center was founded in response to the absence of programs to assist marginalized women living in poverty who are a high risk of contracting HIV/AIDS. The Afiya Center embraces the Reproductive Justice framework as the most effective means for tackling this dual epidemic. The Afiya Center understands that the right to decide what to do with one's own body is at the core of reproductive justice. We believe that women should have the right to make decision about one's own body; to decide if or when, and how to have children; to choose whether to end or continue a pregnancy; to have an equal opportunity to survive pregnancy and childbirth; to parent one's existing children; and to pursue these rights free from systemic violence. We are alarmed that the maternal mortality rates in Texas exceed the rate of maternal deaths in the United States and akin to those of Afghanistan. We believe that the unwillingness to expand Medicaid and the defunding of Planned Parenthood have played a critical role in how Black women have lost access and continuity in their reproductive health care. The stop-gaps are not working. We must create policies that reflect the concern for the rising maternal mortality rates in Texas among Black women. We will not stop raising this issue until we see Black women are able to not only have a viable pregnancy but also live to raise their children.

Black Women's Health Imperative (BWHI) is a national organization dedicated to improving the health and wellness of the nation's 21 million Black women and girls— physically, emotionally, and financially. Its mission is to advance health equity and social justice for Black women, across the lifespan, through policy, advocacy, education, research, and leadership development. For 34 years, BWHI has

championed reproductive health for all women, guided by the belief that quality reproductive health care is a woman's right. BWHI advocates for health promoting policies and opposes laws that burden access to care and disproportionately affect poor women and women of color. Black Women's Health Imperative believes that Black women's health matters and that women's maternal health outcomes and access to care should not depend upon their race or socioeconomic status. BWHI recently contributed chapters on maternal health and reproductive cancers to The State of Black Women & Reproductive Justice Policy Report published by In Our Own Voice: National Black Women's Reproductive Justice Agenda. In January of 2017, BWHI published the first ever report on Black women's health based on healthy Black women. This report contains research on sexual and reproductive health written for the everyday woman.

The National Birth Equity Collaborative (NBEC) is a national organization working to ensure that Black women in the United States survive pregnancy and childbirth, while their babies survive to celebrate their first birthday. In a country where Black maternal and infant mortality are unacceptably high, NBEC's mission is to prevent these deaths through research, family-centered collaboration, and advocacy. NBEC works with organizations, communities, and stakeholders across the United States to develop and implement strategies to achieve maternal and child health equity goals. Birth equity requires the dismantling of racial and social inequalities and the assurance of conditions that support optimal births for all people. For organizations and communities that are ready to face that challenge, NBEC provides training, resources, and technical assistance. NBEC is frequently sought after for its expertise in educating health care providers and institutions about the role that social determinants of health play in shaping birth outcomes, as well as the benefits of community engagement during the design and delivery of health services.

SisterSong: The National Women of Color Reproductive Justice Collective is a Southern-based national membership organization formed in 1997 by 16 organizations, all led by women of color. SisterSong's founding members recognized that their communities have the right and responsibility to represent themselves when matters that impact their reproductive lives are at stake. For twenty years, SisterSong has worked to promote Reproductive Justice and human rights by strengthening and amplifying the collective voices of Indigenous women and women of color who are fighting reproductive oppression. In that time, SisterSong has trained and built an effective network of individuals and organizations working to improve systems and policies that impact the reproductive lives of marginalized communities. SisterSong's policy, advocacy, and community building activities advance the human rights set forth in the reproductive justice framework, including

bodily autonomy, the right to have children, the right to not have children, and the right to parent children in safe and healthy environments. Just as SisterSong has introduced and trained a generation of advocates to defend and aspire to reproductive justice, the organization is currently educating a new generation of advocates and policy makers about the needs and rights of Black women in the area of maternal health.

Women With A Vision (WWAV) is a community-based non-profit that addresses health and social justice issues faced by women in New Orleans, Louisiana, and in the region more broadly. WWAV was founded by a grassroots collective of Black women responding to the spread of HIV/AIDS in their communities. Created by and for women of color, WWAV works to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. WWAV accomplishes this through relentless advocacy, health education, supportive services, and community-based participatory research. WWAV works with populations that are often not visible within the health system and are often denied access to the things they need to lead healthy lives. WWAV places the needs of these women front and center, providing navigator services that connect individuals to women's health services, and advocating for more supportive government policies.

CERTIFICATE OF SERVICE

This is to certify that on the 17th day of October, 2017, I caused the foregoing corrected BRIEF OF *AMICI CURIAE* to be electronically filed with the clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to counsel of record.

/s/ Hillary Schneller
Hillary Schneller
Attorney for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), I hereby certify that this brief complies with the type-volume limitations of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because, excluding the parts of the document exempted by Rule 32(f), the brief contains 6,414 words. This brief complies with the typeface and type style requirements of Rules 32(a)(5) and (a)(6) because it has been prepared in a proportionally-spaced typeface using Microsoft Word in 14-point Times New Roman font, except the footnotes, which are in 12-point Times New Roman font.

/s/ Hillary Schneller
Hillary Schneller
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Dated: October 13, 2017