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IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., and JILL MEADOWS. M.D., Petitioners, v. KIMBERLY K. REYNOLDS ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Equity Case No. EQCE081503 PETITIONERS' POST-TRIAL BRIEF

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

TABLE OF CONTENTS

TABLE OF CONTENTS ii

I. INTRODUCTION 1

II. FACTUAL SUMMARY 2

A. The Act and Its Passage 2

B. Evidence Presented at Trial 3

1. Provision of Abortion Services in Iowa 4

2. PPH's Comprehensive Informed Consent Process 6

3. The Act's Effects 9

a. The Act Would Impose Severe Practical Difficulties on Women Seeking Abortions . 9

b. The Act Would Significantly Delay or Prevent Women From Accessing Abortion . 12

c. These Effects Would Harm Women and Violate Medical Ethics 15

d. The Act Would Endanger Abused Women and Sexual Assault Survivors 17

e. The Act Would Harm Women Seeking Medically-Indicated Abortions 19

f. Women Could Not Avoid these Harms by Seeking Assistance from Other Providers 20

III. LAW APPLICABLE TO PETITIONERS' CLAIMS 24

A. The Act Violates Women's Due Process Rights under the Iowa Constitution 24

1. Under the Iowa Constitution, abortion is a fundamental right and therefore the Act is subject to strict scrutiny review. 24

2. The Act cannot survive strict scrutiny. 27

3. Alternatively, the Act's requirements fail the "undue burden" standard. 31

B. The Act Violates Women's Equal Protection Rights Under the Iowa Constitution. 37

IV. CONCLUSION 41

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

I. INTRODUCTION

Petitioners Planned Parenthood of the Heartland, Inc. ("PPH") and Dr. Jill Meadows proved at trial they are entitled to judgment on their claims that Section 1 of Senate File 471, codified at Iowa Code § 146A (2017) ("the Act"), if permitted to take effect, (1) would violate women's due process rights because it cannot survive either the strict scrutiny test, or alternatively, the undue burden standard, and (2) would violate women's equal protection rights because it cannot survive either the strict scrutiny or intermediate scrutiny standards.[1]

As Petitioners' evidence at trial demonstrated, women who have abortions have already deliberated over their decision, and the vast majority are firm in their decision by the time they schedule the procedure. Once at the clinic, they undergo a robust informed consent process prior to having an abortion. This process already identifies the small percentage of women who are uncertain and provides them with the information, resources, and time they need to make their decision. Given these facts, the Act's requirement of traveling to the clinic two separate times, at least 72 hours apart, serves no legitimate purpose. In addition, the trial testimony showed that the Act would make it significantly harder for women in Iowa to access abortion care, delaying or preventing them and exposing them to a range of medical and other harms. It would be particularly harmful for women who are victims of sexual assault and/or intimate partner violence or who seek an abortion due to concerns for their health.

[1] As explained in Petitioners' Resistance to Respondents' Motion to Dismiss at 21–22 (June 23, 2016), Petitioners' vagueness claims have been partially resolved by intervening events since Petitioners filed their Complaint. A reasonable construction of the Act by this Court—specifically that the terms "indicators" and "contra-indicators" mean the same as the medical terms "indications" and "contraindications"—would resolve Petitioners' vagueness claims entirely.

In sum, the Act is among the most restrictive in the country and would, without any justification, impose extreme burdens on Iowa women seeking to have an abortion. The Act thus violates Petitioners' and their patients' rights as guaranteed by the Iowa Constitution.

II. FACTUAL SUMMARY

A. The Act and Its Passage

The Act requires "[a] physician performing an abortion" to "obtain written certification from the pregnant woman . . . at least seventy-two hours prior to performing the abortion" that she has undergone an ultrasound, has been given the option to view the ultrasound and/or listen to a description of the fetus based on the ultrasound image and the fetus's heartbeat, and has been provided certain information, "based upon the materials developed by the department of public health," including: information about "options relative to a pregnancy," as well as "[t]he indicators, contra-indicators, and risk factors, including any physical, psychological, or situational factors related to the abortion in light of the woman's medical history and medical condition." Iowa Code § 146A.1(1) (2017).

The Act provides only extremely narrow exceptions for: "[a]n abortion performed to save the life of a pregnant woman"; "[a]n abortion performed in a medical emergency"[2]; and "[t]he performance of a medical procedure by a physician that, in the physician's reasonable medical judgment, is designed to or intended to prevent the death or to preserve the life of the pregnant woman." Id. § 146A.1(2)(a)–(c). Physicians who violate the Act are subject to licensee discipline

[2] A medical emergency is narrowly defined as "a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." Iowa Code § 146B.1(6) (2017).

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

by the Board of Medicine ("Board"). Id. § 146A.1(3); Iowa Code § 148.6(2)(c) (2017) ("Pursuant to this section, the board may discipline a licensee who is guilty of any of the following acts or offenses: . . . Violating a statute or law of this state . . . which statute or law relates to the practice of medicine.").

The Act passed the Iowa Legislature on April 18, 2017, with an immediate effective date upon the Governor's signature. The 72-hour mandatory delay provision was added in at the last minute with virtually no debate.[3] Upon learning that then-Governor Branstad intended to sign the Act into law on May 5, 2017, Petitioners immediately moved for temporary injunctive relief in this Court on May 3, 2017. This Court denied relief on May 4, 2017, and Petitioners moved for relief from the Iowa Supreme Court. On May 5, 2017, Governor Branstad signed the Act and it was in effect. However, on that same day, the Iowa Supreme Court temporarily stayed the Act until that Court had an opportunity to receive and consider further briefing. See Order, No. 17-0708 (Iowa May 5, 2017). On May 9, the Iowa Supreme Court extended the stay pending a final hearing and decision in this Court, and ordered the parties to hold a final hearing on the merits on an expedited basis. See Order, No. 17-7078 (Iowa May 9, 2017). This Court held a trial on July 17 and 18, 2017.

B. Evidence Presented at Trial

At trial, Petitioners presented expert and fact testimony from: Dr. Jill Meadows, a board-certified obstetrician-gynecologist ("ob-gyn") and the medical director of PPH; Jason Burkhiser

[3] Chelsea Keenan, Iowa Abortion Bill Comes with Add-Ons, The Gazette, Apr. 16, 2017 http://www.thegazette.com/subject/news/iowa-abortion-bill-comes-with-add-ons-20170416. Furthermore, to add the 72-hour requirement to an unrelated bill, the House voted to suspend the rules on germaneness. See James Q. Lynch, Iowa House Debates 20-week Abortion Ban, The Gazette, April 4, 2017 http://www.thegazette.com/subject/news/government/iowa-house-debates-20-week-abortion-ban-20170404.

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

Reynolds, the manager of PPH's Rosenfield health center in Des Moines; Dr. Daniel Grossman, an ob-gyn with over twenty years of clinical experience and a leading medical researcher in the field of reproductive health care; Dr. Jane Collins, an expert in poverty, gender, and low-wage labor markets; and Dr. Susan Lipinski, a board certified ob-gyn who practices in Waterloo, holds leadership positions in both the Iowa Chapter of the American Congress of Obstetricians and Gynecologists ("ACOG") and the Iowa Medical Society and who herself does not provide abortions except in emergencies. By the parties' agreement, Petitioners submitted written, sworn expert testimony from Dr. Lenore Walker, a clinical and forensic psychologist with decades of expertise in violence against women, including sexual violence, intimate partner violence, and family violence.

Respondents did not present any live testimony. By agreement of the parties, Respondents submitted written testimony by Mark Bowden, Executive Director of the Board, stating that the Board would promulgate rules implementing the Act, see Resp't's Trial Ex. M; and by Melissa Bird, Bureau Chief of Health Statistics at Iowa Department of Public Health, presenting vital statistics on where abortion patients resided in 2014 and 2015, see Resp't's Trial Ex. I.

1. Provision of Abortion Services in Iowa

PPH provides a wide range of healthcare at its Iowa health centers, including well-woman exams, cancer screenings, testing and treatment for sexually transmitted infections, contraceptive counseling and care, transgender healthcare, and medication and surgical abortion. Tr. of Bench Trial Vol. I ("Tr. I") at 11:9–21 (Meadows), 103:22–104:3 (Reynolds). Petitioner Dr. Jill Meadows testified that over the past year (April 1, 2016 to March 31, 2017), PPH provided over 2000 medication abortions and over 1000 surgical abortions in Iowa. Tr. I at 18:1–8 (Meadows). PPH provides both surgical and medication abortion at two clinics in Iowa, in Des Moines and Iowa

City. Tr. I at 16:9–13 (Meadows). Currently another four of PPH's health centers—in Ames, Bettendorf (Quad Cities), Cedar Falls, and Council Bluffs—provide only medication abortion, which is an early method of ending a pregnancy using pills rather than surgery.[4] Tr. I at 16:9–13 (Meadows); Pet'rs' Trial Ex. 10, Expert Disclosure of Dr. Jill Meadows, M.D. ("Meadows Disclosure") ¶ 7. The Bettendorf health center will close in the near future. Tr. I at 17:16–23 (Meadows).

As Petitioners witnesses testified, women decide to terminate a pregnancy for a variety of reasons, including familial, medical, financial, and personal reasons. Nearly one in three women in this country will have an abortion by age forty-five. Tr. I at 138:8–11 (Grossman). The majority of women who seek abortions are mothers who have decided that they cannot parent another child at this time, and most women seeking abortions plan to have children (or additional children) when they are older, financially able to provide necessities for them, and/or in a supportive relationship with a partner so that their children will have two parents. Pet'rs' Trial Ex. 11, Expert Report of Dr. Daniel Grossman, M.D. for Pet'rs ("Grossman Report") ¶ 8; see also Tr. I at 138:12–21 (Grossman). As Dr. Meadows explained, most women seeking an abortion have considered their own situation and concluded that "[f]or financial, physical, psychological, or situational reasons they're just not in a place where they can be the parent that they want to be." Tr. I at 22:22–24 (Meadows).

[4] Previously, PPH had been able to offer medication abortion at additional health centers in the state. As Dr. Meadows explained, because of a recent law banning PPH from participating in Iowa's Medicaid waiver family planning program, PPH had to close several of its health centers in the state in late June 2017, including health centers that also provided medication abortion. Tr. I at 16:14–17:6 (Meadows).

2. PPH's Comprehensive Informed Consent Process

As the uncontroverted trial testimony showed, PPH obtains the informed consent of abortion patients. Dr. Meadows, who has provided reproductive health care services for over twenty years, including medication and surgical abortions to tens of thousands of patients, Tr. I at 12:14–18 (Meadows), testified that abortion patients are provided with all information necessary for them to understand the risks and benefits of abortion and of the alternatives to abortion, and make a fully informed and voluntary decision to have an abortion. Tr. I at 19:21–21:12 (Meadows).

Jason Burkhiser Reynolds, who has spoken to, and provided patient education to, hundreds of PPH's abortion patients, Tr. I at 103:12–21, 105:18–106:1 (Reynolds), and Dr. Meadows both testified about PPH's comprehensive patient education process—available on the day of the procedure—which, inter alia, gives patients multiple opportunities to ask questions and discuss any concerns they may have. Tr. I at 19:21–21:12 (Meadows), 114:17–115:10 (Reynolds). Trained staff members who take patients through this process ask open-ended questions, discuss with patients their decision-making process and state of mind, and identify any red flags that suggest a patient may not be certain that she wants to have an abortion. Tr. I at 20:5–20 (Meadows), 106:16–22, 114:17–115:25, 117:13–118:22 (Reynolds). Indeed, the trial record is void of any evidence that a single woman in Iowa underwent an abortion without first giving informed and voluntary consent.

Consistent with Iowa law, see Iowa Code § 146A.1 (July 2015), and in accordance with PPH's medical guidelines, PPH also provides an ultrasound to every woman seeking an abortion and gives her the opportunity to view the ultrasound, if she chooses. Tr. I at 24:12–25 (Meadows). And as the trial testimony showed, the majority of patients do not choose to view the ultrasound.

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

Tr. I at 25:9–11; see also Tr. 1 at 153:14–17 (Dr. Grossman testifying to the same experience in his practice).

The trial testimony showed that the overwhelming majority of PPH's abortion patients have researched and are aware of their options and are certain in their decision to terminate their pregnancy by the time they *arrive* at their appointment. Tr. I at 25:12–25 (Meadows), 116:14–119:18 (Reynolds); see also Tr. I at 151:10–152:10 (Grossman). To reach that point, abortion patients "have thought long and hard about this decision, and they have made a careful and considered decision about what is best for them and their family," after seeking out information and conferring with others. Tr. I at 15:16–19 (Grossman). This is consistent with peer-reviewed research conducted on patient certainty before abortion. In fact, studies show that patients were as or more certain of their decision to have an abortion than patients presenting for other medical procedures or treatments. Tr. I at 154:4–158:7, 164:1–8 (Grossman).

When a patient is not certain that she wishes to terminate her pregnancy, PPH works with her to articulate and consider the values, goals, and circumstances relevant to her decision. Tr. I at 26:6–19 (Meadows), 119:8–18 (Reynolds). PPH informs her about resources available to her if she decides to carry to term, such as adoption agencies (including an agency that will meet her in the clinic to facilitate the process), prenatal care, public assistance, and other resources. Tr. I at 23:5–24:7 (Meadows), 116:20–117:4, 119:10–15 (Reynolds). If this process does not point a patient to a clear decision, PPH will advise her to take more time to consider her options. Tr. I at 26:6–19 (Meadows). Sometimes, the patient education process clarifies for a patient that she wants to continue her pregnancy, and PPH provides her with resources to support her in that decision. Tr. I at 23:5–13 (Meadows), 119:10–15 (Reynolds).

As for the women who proceed with the abortion, studies show that "both immediately after the abortion and looking back even years later, the vast majority of [them] reflect on their decision as being the right decision for them at that point in their lives." Tr. I at 158:12–16 (Grossman). Indeed, several of Petitioners' witnesses testified that they heard from patients later that they feel they made the right decision, and that they have never had a patient tell them she made the wrong decision, or that she wishes she had taken more time with that decision. Tr. I at 120:17–121:7 (Reynolds), 160:7–22 (Grossman).[5]

The trial testimony demonstrated that PPH's practices, including its same-day provision of abortion care, are consistent with the standard of care, good medical practice, and medical ethics. Tr. I at 55:10–23 (Meadows), 150:1–153:7 (Grossman). PPH's informed consent practices are also consistent with Iowa law and the way informed consent is provided for other procedures. See, e.g., Estate of Anderson ex rel. Herren v. Iowa Dermatology Clinic, PLC, 819 N.W.2d 408, 416 (Iowa 2012); Morgan v. Olds, 417 N.W.2d 232, 235 (Iowa Ct. App. 1987) (citing Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 358 (Iowa 1987)). Informed consent includes disclosing "information material to a patient's decision to consent to medical treatment," Estate of Anderson ex rel. Herren, 819 N.W.2d at 416, and "all material risks involved in the procedure," Doe v. Johnston, 476 N.W.2d 28, 31 (Iowa 1991). Moreover, ob-gyns routinely perform a wide range of same-day medical procedures if that is the patient's preference. Tr. of Bench Trial Vol. II ("Tr. II") at 207:12–208:6 (Lipinski); Pet'rs' Trial Ex. 16, Expert Rebuttal Report of Dr. Susan Lipinski ("Lipinski Report") ¶¶ 18–19. Prior to the Act, Iowa did not require a mandatory delay and additional clinic trip for *any* medical procedure, including abortion.

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[5] Consistent with this evidence, Petitioners also presented evidence that mandatory delay periods, while they make abortions harder to obtain, do not actually *persuade* patients not to have an abortion. Tr. I at 164:20–166:2, 175:13–24 (Grossman).

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

3. The Act's Effects

The evidence at trial proved that the Act, which imposes one of the three strictest mandatory delay periods in the country, would severely burden and obstruct patients' access to abortion.

a. The Act Would Impose Severe Practical Difficulties on Women Seeking Abortions

Even prior to the Act, women faced many obstacles in accessing abortion in Iowa. The majority of PPH's abortion patients are living close to or below the federal poverty line and face tight constraints scheduling time off from work (which is often unpaid), arranging childcare and transportation, and paying for the procedure (which is often not covered by private insurance and rarely covered by Medicaid), particularly if they are trying to keep their decision to have an abortion confidential. Tr. I at 38:18–39:21 (Meadows), 122:2–13 (Reynolds); 145:2–21 (Grossman). As Dr. Collins explained, low-income women are less likely to live in households with a car or to have access to a car, especially one suited for a long trip. Tr. II at 126:11–127:23 (Collins). Public transportation between counties in Iowa is limited and infrequent and thus may require overnight stays. Tr. II at 126:7–8, 128:10–130:17 (Collins). Indeed, Dr. Lipinski testified that her patients often miss appointments or referrals, or have to arrive very early or late for their appointment, because they have to rely on limited public transportation or otherwise make do with limited transportation. Tr. II at 205:16–206:11; see also Tr. I at 37:13–14 (Dr. Meadows testifying that PPH "hear[s] on a regular basis how patients have had difficulty in arranging transportation . . . ."). Low income women also often have minimum wage jobs in which time off is limited, unpaid (which results in lost wages), and/or difficult to schedule in advance, and can even jeopardize their position. Tr. II at 130:21–132:6 (Collins).

Not only must women manage these constraints, but many of them must do so while traveling far to reach an abortion provider. In part because of limited provider availability and in part because of a medically unnecessary statutory restriction preventing qualified, licensed advanced-practice clinicians from providing abortions, abortion access is already limited in Iowa. Tr. I at 142:1–144:16 (Grossman). Currently 27.8% of women of reproductive age in Iowa, or about 162,000 women, live in a county at least 50 miles from the nearest abortion provider in the state. About 260,000 women of reproductive age, or 44% of this population in Iowa, live in a county that is 50 miles or farther from the nearest facility providing surgical abortion in the state—which, depending on gestational age and other factors, is often a woman's only option for obtaining an abortion. Tr. 1 at 143:2–9 (Grossman). The numbers are even starker for the historic patient data from prior vital statistics reports; based on the most recent published data (which includes patients who travel to Iowa from neighboring states), close to half of patients live in regions far more than 50 miles from current providers. Tr. I at 143:10–144:9 (Grossman). By either measure, the percentage of women who must travel over 50 miles is far higher than the national average of 17%. Tr. I at 144:10–16 (Grossman).

The Act would severely compound these already-existing obstacles by requiring patients to jump through these same hurdles an additional time, forcing almost half of the state's population to travel *at least* 200 miles roundtrip (i.e., two 100-mile roundtrips) to obtain a surgical abortion. These Iowa women would have to: forgo more wages, explain their multiple absences to an employer (as well as to family members and others), risk their jobs, be away from their families, and/or pull together more money and other resources for transportation and childcare. Tr. I at 37:10–18 (Meadows), 145:8–21, 173:9–21, 178:14–179:20 (Grossman); Tr. II at 132:7–10, 133:4–136:8 (Collins); Meadows Disclosure ¶ 27. These arrangements would be particularly hard for

adolescents, women who live far from a clinic, women with inflexible work schedules and/or work that does not afford paid time off, parents, women with limited transportation resources, and women who need to conceal their decision from a controlling or abusive partner or from others. Tr. I at 38–39 (Meadows), 126:3–18, 128:17–129:14 (Reynolds), 145:15–21 (Grossman); Tr. I at 164:12–15 (Grossman) (study finding that "low-income women and women living at least 20 miles from the clinic were significantly more likely to report that it was hard to get to the clinic for [the extra consultation] visit"); Meadows Disclosure ¶ 22. Women who live far from the clinic would also face particularly high travel costs, including potentially hotel costs for several nights if they were unable to make two separate trips to the health center at least 72 hours apart. Tr. II at 129:16–130:17 (Collins, estimating an additional $208 in travel expenses for women who live in Ottumwa, and $273 for women who live in Sioux City, from being timed out of medication abortion as a result of the Act and being forced to travel to a health center that offers surgical abortion).

Dr. Collins testified that, because low income women are often living with expenses that exceed their income, these additional costs could amount to a "major financial shock and setback" for women and their families, and would result in women living at or near the poverty line skimping on food and other basic necessities for themselves and their families, falling behind on bills, and taking on debt they cannot afford. Pet'rs' Trial Ex. 13, Expert Report of Dr. Jane Collins ¶ 43 ("Collins Report"); Tr. II at 106:5–12 (Collins); see also Tr. I at 147:17–148:21 (Grossman) (research indicates that even without significant state-imposed barriers, low-income patients already forego these necessities to pay for the procedure and related costs). The process of finding and saving money to pay for additional costs resulting from the Act would further delay some

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

women and will make it impossible for others to terminate their pregnancy.[6] Tr. II at106:13–21; 147:23–150:12 (Collins).

b. The Act Would Significantly Delay or Prevent Women From Accessing Abortion

Petitioners' witnesses testified, because of these realities, the Act would substantially delay women seeking an abortion. Not only would it force women to make far more complicated and costly arrangements, but it would also increase wait times for abortion appointments because it would require abortion providers to schedule an extra, medically unnecessary appointment for all patients. PPH's health centers are already stretched thin. Tr. I at 49:7–17 (Meadows). Due to limited clinician availability and the fact that PPH is restricted by other laws from expanding access to care, PPH is only able to schedule abortion patients 1–3 days a week at some of its health centers, and even less frequently at the others. Tr. I at 46:22–47:2, 49:3–6 (Meadows). As a result, staff already have to schedule patients anywhere from one to two weeks out or even longer. Tr. I at 47:13–21 (Meadows). If PPH had to schedule an extra appointment for each patient, these delays would be even greater and would also affect PPH's ability to provide timely care to non-abortion patients.[7] Tr. I at 47:22–49:17 (Meadows).

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[6] Respondents' counsel suggested at trial that existing burdens were irrelevant to the constitutional analysis because they are not *caused* by the Act. As explained below in Part III.A.3., this suggestion fundamentally misunderstands the undue burden analysis, which examines how a particular restriction might interact with other barriers (state created and otherwise) to burden, harm, delay, or prevent women seeking an abortion.

[7] Indeed, as Dr. Meadows testified, this is exactly what occurred when Arkansas, where PPH previously provided abortions, enacted a two-trip, 48-hour waiting period (prior to that, it had required a shorter waiting period and allowed the first interaction to be over the phone). Tr. I at 51:2–13. In Iowa, there is also a danger that the delay from increased appointments will be compounded by increased demand for abortion in light of a recent, politically motivated law barring patients from receiving subsidized family planning care at Planned Parenthood centers. Tr. II at 40:21–41:5 (Grossman).

Indeed, these effects have occurred in other states that have imposed similar or even lesser waiting periods. One Utah study showed an *average* delay of eight days resulting from a 72-hour mandatory delay law, with the majority of patients delayed over a week and some patients still seeking care *several weeks* later. Tr. I at 173:1–8, 177:20–178:11 (Grossman). Another study, of Alabama's 48-hour delay law, showed that 12% of women were delayed far longer, 14–53 days, and that women who were lower income or lived farther from care were significantly more likely to be delayed. Tr. I at 180:10–181:13 (Grossman); see also Tr. I at 181:19–182:12 (Grossman) (sharp increase in second trimester abortion rates in Mississippi after 24-hour mandatory delay law went into effect). Because Iowa women already travel far to reach an abortion provider and because the Act imposes a severe 72-hour minimum delay, the Act is likely to cause similar or worse delays in Iowa.

Importantly the Act would impose this delay on women against their express wishes; in one study of Iowa abortion patients, 94% of those surveyed stated that it was "very important" to them that they have an abortion "as soon as possible," and other research reports similar levels of high preference for immediate care. Tr. I at 141:3–12 (Meadows), 176:7–177:6 (Grossman).

By causing significant delays, the Act would prevent many women from obtaining a medication abortion, because this method is only available in the first ten weeks of pregnancy (measured from the first day of the woman's last menstrual period) and many of PPH's patients present for care close to the end of this time-window.[8] Tr. I at 28:11–14, 30:10–21 (Meadows).

[8] Last year over 600 patients received a medication abortion in their ninth or tenth week of pregnancy. Tr. I at 30:10–15 (Meadows). More recently, there have been over 50 patients a month close to the cut off. Tr. I at 30:10–15 (Meadows). Iowa's vital statistics demonstrate that over half of the abortions performed in 2015 in the state were medication abortions. 2015 Vital Statistics of Iowa at 134, Iowa Dep't of Pub. Health, Bureau of Health Stats. https://idph.iowa.gov/Portals/1/userfiles/68/HealthStats/vital_stats_2015-20170307.pdf.

This would harm women, many of whom strongly prefer medication abortion to surgical abortion; for example, for sexual assault survivors, medication abortion may feel less invasive and, for that reason, may be far easier to undergo, Tr. I at 28:15–25 (Meadows), 122:14–123:1 (Reynolds), 139:3–141:5 (Grossman). For some women, this method is medically indicated, Tr. I at 28:25–29:6 (Meadows); by pushing some of these women beyond the ten-week limit, the Act would force them to undergo a riskier surgical procedure, Tr. I at 30:22–31:5 (Meadows). And even for those women who could still access medication abortion, forced delay would be harmful because medication abortion is more effective the earlier it is initiated. Tr. I at 29:12–18 (Meadows).

Women who were pushed past the cut-off for medication abortion would often have to travel significantly farther to get a surgical abortion (in addition to forcing them to make an additional trip to an abortion clinic), particularly in northern and western Iowa. Tr. I at 183:15–184:12 (Grossman). As stated above, PPH only provides surgical abortion at two of its health centers, in Des Moines and Iowa City; medication abortion is currently available at six health centers, which are spread across the state in Des Moines, Iowa City, Ames, Cedar Falls, Council Bluffs, and (temporarily) Bettendorf (Quad Cities). See Part II.B.1, above. Thus, for example, a patient in Council Bluffs who loses her chance to have a local medication abortion via telemedicine would not only have to schedule an additional medical visit but also travel approximately 270 additional miles round-trip to Des Moines for her procedure. And as Dr. Meadows testified, for other women seeking a surgical abortion later in pregnancy, the mandatory delay would push them past the gestational age at which surgical abortions are available in the state. Tr. I at 31:21–32:8 (Meadows).

By forcing women to travel farther distances (as well as schedule an additional medical visit), the Act is likely to delay women still further and to prevent some women from obtaining an

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abortion. Tr. I at 162:2–15 (Grossman); Tr. II at 205:6–207:8 (Lipinski). Evidence from other states shows that, when women have to travel farther to a clinic, they are less likely to access an abortion early in their pregnancy and also less likely to access an abortion at all. Tr. I at 184:13–21, 185:1–189:9 (Grossman); see also Planned Parenthood Se., Inc. v. Strange, 33 F. Supp. 3d 1330, 1356 (M. D. Ala. 2014) (reviewing and crediting this evidence). There is also some evidence that, distance aside, the requirement of multiple visits, on its own, prevents some women from having an abortion. In a study of Utah's 72-hour waiting period, some women reported that they were no longer seeking an abortion because of financial constraints or because the mandatory delay period pushed them past a gestational cut-off. Tr. II at 93:8–94:4 (Grossman); Tr. I at 179:21–180:4 (Grossman) (discussing Sarah C.M. Roberts, et al. Utah's 72-Hour Waiting Period for Abortion: Experiences Among Clinic-Based Sample of Women, 48 Persps. on Sexual and Reprod. Health 179 (2016)); Tr. I at 170:1–21 (Grossman) (citing research indicating that patients were delayed, and some prevented, after Texas's mandatory delay went into effect).

c. These Effects Would Harm Women and Violate Medical Ethics

As the trial testimony showed, by delaying women for a week or longer, the Act would expose women to health risks and other harms. While abortion is an extremely safe procedure, the risks associated with it increase as the pregnancy advances, even week-to-week. Tr. I at 31:2–5 (Meadows), 187:3–10 (Grossman). A second trimester abortion, while still safer than childbirth, is 8–10 times riskier than a first-trimester abortion. Tr. II at 57:4–11 (Grossman). Mandatory delays also causes women significant stress; make them feel stigmatized and powerless; jeopardize the confidentiality of their decision; force some to endure pregnancy symptoms such as vomiting, or even more severe pregnancy-related conditions, for longer; make it harder or impossible for them to have their chosen support person there for the procedure; and (as set forth below) can put them in danger of domestic violence. Tr. I at 51:24–52:15 (Meadows), 141:14–23, 150:6–15,

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176:6–179:20 (Grossman); see also Tr. I at 124:2–126:15 (Reynolds) (describing how, when the Act briefly took effect, patients were extremely distraught and some were unsure whether they would be able to make the additional trip); Tr. I at 163:13–22 (Grossman) (in one study, 31% of patients reported that "waiting period had a negative effect on their emotional well being").

In addition, abortion becomes far more costly later in pregnancy, because a more complex procedure is required. Tr. I at 162:8–15 (Grossman). Those increased costs would come on top of additional clinic-related costs from extra appointments, costs which will have to be passed down to the patient, Tr. I at 50:19–24 (Meadows), as well as increased travel-related costs. As explained above, these costs would be an economic shock to PPH's low-income patients, who either would not be able to afford them or would have to skimp on basic necessities to do so. See Part II.B.3.a, above.

Women who are deprived of access to safe, legal abortion face a range of harms, as do their families. Childbirth poses far greater health risks than abortion. See Grossman Report at 11; Tr. I at 189:12–16 (Grossman). Moreover, there is evidence that women forced to carry an unwanted pregnancy to term are at increased risk of preterm birth (which can have serious adverse health effects for the baby) and failure to bond with the baby; and are less likely to escape poverty, less likely to escape domestic violence, and less likely to formulate and achieve educational, professional and other life goals. Tr. I at 189:17–195:19 (Grossman). Additionally, when women lack access to safe, legal abortion, some become desperate enough to attempt to self-induce an abortion, which can further jeopardize their health or life. Tr. I at 195:20–198:6 (Grossman).

Because mandatory delay laws like the Act harm women's health, they are opposed by ACOG, the leading women's health organization. Tr. I at 198:7–201:5 (Grossman). The Act also squarely violates core principles of medical ethics. Specifically, the Act violates the principle of

patient-centered care, which requires that care be "respectful of, and responsive to, individual patient preferences, needs and values," and that all clinical decisions be guided by *patient* values. Tr. I at 35:14–19 (Meadows). The Act violates other principles of medical ethics as well: the requirements that providers do their patients no harm and preserve patient autonomy. Tr. I at 55:12–56:12 (Meadows), 160:23–61:11, 203:18–204:1 (Grossman); Tr. II at 185:2–186:3 (Lipinski).

Finally, the Act is harmful because it perpetuates the gender stereotype that women do not understand the nature of the abortion procedure, have not thought carefully about their decision to have an abortion, and are less capable of making an informed decision about their health care than men. Tr. I at 36:5–11 (Meadows); Meadows Disclosure ¶ 49. The Act also stigmatizes women seeking abortions and sends the harmful message that they are incompetent decision-makers. Tr. I at 36:5–11, 55:19–56:12 (Meadows); Meadows Disclosure ¶ 49.

d. The Act Would Endanger Abused Women and Sexual Assault Survivors

The mandatory delay and additional trip requirements would pose particular harms to especially vulnerable groups of Iowa women. Dr. Lenore Walker testified that the Act's requirements pose a very real threat to women's confidentiality and privacy, and would endanger women who are being abused or are at risk for abuse. Pet'rs' Trial Ex. 4, Aff. of Lenore E.A. Walker, Ph.D for Pet'rs ("Walker Aff.") ¶¶ 7, 29; see also Tr. I:127:11–17 (Mr. Reynolds testifying that in his experience from speaking to PPH's patients, domestic abuse victims would have trouble complying with the Act's requirements). Dr. Walker testified that studies show the lifetime cumulative rate of abuse for women seeking abortions to be at 27–31%. Walker Aff. ¶ 9 n.2. She also testified that according to the CDC, 31.3% of Iowa women have experienced rape, physical violence, and/or stalking by an intimate partner. This amounts to over 360,000 Iowa women.

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

Walker Aff. ¶ 11. And one study found that for women seeking an abortion in Iowa, 13.8% had been subjected to physical or sexual abuse in the past year alone.[9] Walker Aff. ¶ 9 n.2.

Because abusers often use contraceptive sabotage and forced pregnancy as a way of keeping their partners under control and closely monitor their partners, many abused women will find it extremely difficult, and perhaps impossible, to arrange and attend an additional, medically-unnecessary abortion-related health visit. Walker Aff. ¶¶ 16, 19–20; Tr. I at 145:18–147:13 (Grossman). Mr. Reynolds testified that PPH's Iowa patients struggle to preserve confidentiality, often for fear of abuse, and that any trip they have to make to the clinic poses a serious challenge. Tr. I at 122:4–13, 127:1–17 (Reynolds). Similarly, Dr. Grossman testified:

> I have had patients where they're in dangerous social situations with a violent partner, for example, and sometimes they're even in a situation where their partner doesn't let them go out of the house and they have somehow been able to get out so that they could get to a health care facility to receive the care that they want, and it's unclear when they're going to be able to get out again.

Tr. II at 7:2–9 (Grossman). By making it harder for abused women to obtain an abortion, the Act would also make it harder for them to escape that abuse. Walker Aff. ¶ 17 (carrying unwanted pregnancy to term may make it more difficult to leave abusive relationship). Similarly, Dr. Walker explained that the Act would endanger adolescents at risk of partner or family abuse by

[9] Indeed, Mr. Reynolds testified that even within the few hours that the Act took effect on Friday, May 5, 2017, at least two patients who were pregnant from rape were at risk of having their abortion delayed by the Act's onerous requirements. Tr. I at 125:6–11 (Reynolds); Pet'rs' Trial Ex. 10, Expert Disclosure of Jason Burkhiser Reynolds ("Reynolds Disclosure") ¶¶ 12, 19; see also Tr. I at 52:16–53:3 (Dr. Meadows testifying that she personally sees patients who are pregnant as a result of sexual assault at least once a month, if not more, and having to make multiple visits would force these patients to relive their trauma); Br. of Amicus Curiae on Behalf of Iowa Coalition Against Domestic Violence, et al. in Supp. of Petitioners-Appellants, Planned Parenthood of the Heartland, Supreme Court No. 14-1415 at 24 (Iowa Nov. 10, 2014), available at https://nwlc.org/wp-content/uploads/2015/08/telemedicine_brief_formatted_11_12_3.pdf.

compromising their privacy and by making it harder or impossible for them to terminate an unwanted pregnancy.[10] Walker Aff. ¶ 26.

As Dr. Walker testified, forcing women whose pregnancies are the result of rape or other violent crimes to comply with the Act's requirements may cause them further psychological harm, raise privacy and confidentiality concerns, and even prevent them from accessing care altogether. Walker Aff. ¶¶ 18–20, 27–30; see also Tr. I at 201:9–202:3 (Dr. Grossman testifying to same). Moreover, Dr. Grossman testified that some sexual assault survivors are unable to face their pregnancy until the second trimester, and at that point are anxious to terminate as soon as possible and worried that they will pass the gestational age cut-off for an abortion. Tr. I at 203:1–7. As Dr. Meadows explained, forcing these patients to have an extra medical appointment makes them "reliv[e] that trauma each time" and delays them when they "just want to terminate the pregnancy as soon as possible so that they can emotionally move on." Tr. I 52:18–53:3.

The Act makes no exceptions for any of these circumstances.

e. The Act Would Harm Women Seeking Medically-Indicated Abortions

Women with wanted pregnancies who seek abortions to protect their medical well-being would also be at risk of grave harm, unless they fit within the Act's narrow exception by being at serious risk of losing their lives or impairment of "a major bodily function" (a determination their physician must make knowing she could lose her license if the Board disagrees). See Iowa Code §§ 146A.1(2), 146B.1(6) (2017). The Act would impose serious medical risks to women facing one of the numerous complications of pregnancy that threaten a woman's health, potentially outside the dangerously narrow confines of the Act's exceptions, such as eclampsia, hypertension,

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[10] Petitioners' witnesses testified that the Act's requirements are also likely to be particularly burdensome, if not prohibitive, for minors seeking an abortion without parental involvement, who are already required by Iowa law to navigate a judicial bypass before obtaining care. Tr. I at 128:4–129:3 (Reynolds); Iowa Admin. Code 641-89.21(135L) (2017).

renal disease, or premature rupture of the membranes. Tr. I at 54:7–19 (Meadows), 201:18–25 (Grossman); Tr. II at 6:18–7:1 (Grossman), 208:15–209:3 (Lipinski).

Likewise, for women who make the painful decision to terminate a wanted pregnancy after receiving an unexpected diagnosis of a severe fetal anomaly, the mandatory delay and additional-trip requirements would be especially cruel. Dr. Grossman testified that in his clinical experience he has "seen the stress, the way that they are just—the way this destroys them and just destroys their life," and he see this situation as "an issue of addressing their mental health needs by trying to perform the abortion as quickly as possible." Tr. II at 10:10–23. Contrary to that clinical imperative, the Act's requirements would prolong that painful and anxious experience for patients, and would interfere with Petitioners' ability to exercise medical judgment and provide compassionate care to these patients. Tr. I at 54:24–55:23 (Meadows), 202:4–13 (Grossman); Tr. II at 207:9–19 (Lipinski).

Furthermore, women who receive a fetal anomaly diagnosis are often close to the point in pregnancy when they can no longer have an abortion in Iowa. Tr. I at 32:21–33:6, 53:4–11 (Meadows); Tr. II at 209:20–210:10 (Lipinski). Under the Act, patients would have increased anxiety about missing that cut-off, and some might be pressured to terminate before they had a complete diagnosis. Tr. II at 210:11–16 (Lipinski). Others *would* pass that cut-off and be forced to travel out of state if they could, or else carry a severely compromised pregnancy to term. Tr. II at 210:17–20.

f. Women Could Not Avoid These Harms by Seeking Assistance from Other Providers

Under the current status quo (i.e., absent the Act), Petitioner's patients are able to be screened and have the abortion in a single medical appointment at PPH. Under the Act, every patient would either need to make an additional trip to PPH for advance screening at least 72 hours

before her procedure or obtain this screening elsewhere. Specifically, the Act requires each patient to certify in writing and transmit to her abortion provider, at least 72 hours before her abortion, that: she has received an ultrasound; she has been giving the option of seeing and/or hearing that ultrasound and/or having it described; and that she has received certain information "based on" state materials created by the Department of Health, including risk factors "in light of the woman's medical history and medical condition." Iowa Code § 146A.1(1)(b). The uncontroverted evidence at trial demonstrated that it would be very difficult, and often impossible, for Iowa women outside of most metropolitan areas to obtain these services at a local health care provider for numerous reasons.

Dr. Meadows presented unrefuted expert testimony that, at a minimum, to convey the required individualized risk factor information, a provider would need an ultrasound report and images, bloodwork, and a medical history. Tr. I at 39:22–40:6 (Meadows). Dr. Lipinski provided detailed expert testimony as to why patients could not generally meet these requirements without traveling to PPH for the initial visit. Tr. II at 187:11–205:15 (Lipinski). To begin with, abortion patients are intensely concerned about the privacy of their decision, and often it is very important to them that it be kept confidential from other providers; in Dr. Lipinski's experience, "[i]t's one of their greatest concerns." Tr. II at 197:16–18 (Lipinski); see also Tr. I at 39:13–21 (Meadows). Sadly, abortion patients often experience shaming and mistreatment by other providers who *do* find out about their decision. Tr. I at 44:16–24 (Meadows). Many rural patients also would feel uncomfortable seeking care from a local provider out of fear that they would run into people they know in the waiting room. Tr. I at 44:8–15 (Meadows); Tr. II at 197:5–15 (Lipinski).

Moreover, many physicians are strongly opposed to abortion, and therefore would be highly unlikely to help women seeking to comply with the Act. Tr. II at 196:19–24 (Lipinski).

Others, while willing, would be prevented by professional restrictions or concerns. Tr. II at 198:2–201:22 (Lipinski). For example, many Iowa physicians are employed by Catholic hospital systems, which bar them from providing any care that would facilitate an abortion. Tr. II at 198:2–201:22 (Lipinski). Others face restrictions because they lease office space from, or hold admitting privileges at, religious healthcare organizations. Tr. 1 at 198:2–201:22 (Lipinski). Still others, even if supportive, would be reluctant to help because professionals associated with abortion are targeted for harassment and even violence. Tr. II at 198:2–24, 202:5–03:18 (Lipinski); see also Tr. I at 49:19–50:8, 199:18–200:20 (Meadows); Tr. I at 173:22–74:4 (Grossman) (citing research finding that in Utah, while the law allowed non-abortion providers to perform the state-mandated pre-abortion counseling, "very few" did); Strange, 33 F. Supp. 3d at 1350, 1252–53 (physician ostracized and harassed for providing *coverage* for *post*-abortion care; another clinic was unable to find a provider for such coverage).

Even if a patient were comfortable seeking pre-abortion screening from a local provider and that provider were willing to help her and not barred from doing so, the trial testimony showed that this option would not be remotely realistic for most women. There is a severe ob-gyn shortage in Iowa, particularly in the areas far from the metropolitan areas where PPH operates health centers, and the overwhelming majority of non-ob-gyns do not provide ultrasounds. Tr. II at 186:4–88:14 (Lipinski) & Pet'rs' Trial Ex. 71. A non-ob-gyn might refer a patient to a radiology center after seeing (and charging) her for a new patient visit, but that radiology center would charge her for a comprehensive ultrasound (typically more expensive) and often would not be able to offer her a description of the ultrasound (as the Act requires). Tr. II at 190:4–93:22 (Lipinski); Tr. II at 141:16–142:16 (Collins). Even if the woman could overcome these hurdles and additional costs (and the evidence summarized above shows how unlikely this is), the process of scheduling these

multiple appointments and waiting for results to be transmitted would be burdensome and impose significant delays—potentially weeks—before she could even receive the required medical information and sign the necessary certification (assuming a non-ob-gyn who does not perform abortions even felt comfortable counseling a patient about risks associated with abortion, which some would not, Tr. II at 196:14–25 (Lipinski)). Tr. II at 194:23–95:12 (Lipinski); see also Tr. I at 40:7–41:11 (Meadows); Tr. II at 144:16–146:7 (Collins).

And even if a rural patient were lucky enough to have an ob-gyn nearby who could perform an ultrasound in-office, wait times in these areas are typically up to 6 weeks for this specialty care, which would be prohibitive for an abortion patient. Tr. II at 189:10–15 (Lipinski); see also Tr. I at 43:4–44:4 (Meadows). Ob-gyns, moreover, also would charge for a new patient visit as well as for the ultrasound and, in many cases, would have to send bloodwork to an external lab and wait for it to come back before even providing the pre-abortion risk factor counseling at a subsequent visit, thus compounding delays and associated costs. Tr. II at 189:10–90:14 (Lipinski); Tr. II at 141:8–13 (Collins).

These "alternative" scenarios could not stand in starker contrast to the current situation, in which women are able to receive this specialized care from a single, experienced and competent provider, in a cost-effective manner, on the day of their procedure.[11]

[11] Additionally, patients who sought their initial care from a non-abortion provider might face substantial additional costs from having multiple ultrasounds. As Drs. Meadows and Lipinski explained, the quality of pregnancy dating ultrasounds and ultrasound reports can vary significantly, particularly because technicians at radiology centers and rural hospitals often have limited experience with this type of ultrasound, and both doctors have seen inaccurate ultrasound reports from other providers. Tr. I at 41:12–42:12 (Meadows); Tr. II at 192:12–93:22, 195:7–96:7 (Lipinski).

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

III. LAW APPLICABLE TO PETITIONERS' CLAIMS

A. The Act Violates Women's Due Process Rights under the Iowa Constitution

1. Under the Iowa Constitution, abortion is a fundamental right and therefore the Act is subject to strict scrutiny review.

The Iowa Supreme Court has recognized that abortion is a right protected under the Iowa Constitution. Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252, 263, 269 (Iowa 2015) (striking down under the Iowa Constitution an agency rule restricting the use of telemedicine to provide abortion); see also Resp'ts' Mot. to Dismiss 9 (May 23, 2017) (acknowledging "a pregnant women has a right to access an abortion"). In Planned Parenthood of the Heartland, the Iowa Supreme Court noted that many state courts have afforded this right greater protection under their state constitutions than the "undue burden" standard of protection provided under the U.S. Constitution. 865 N.W.2d at 262 n.2 (citing examples from Alaska, Florida, Minnesota, Montana, and Tennessee). The Court did not reach the question of whether the *Iowa* Constitution affords such heightened protection because the restriction PPH challenged failed the minimum standard established by federal precedent. Id. at 263.

More recently, however, the Iowa Supreme Court held that the Iowa Constitution guarantees a fundamental right to procreate, because "the due process clause of our constitution exists to prevent unwarranted governmental interferences with personal decisions in life," and that any infringement on this right is subject to strict scrutiny review. McQuistion v. City of Clinton, 872 N.W.2d 817, 832 (Iowa 2015) (citing both state and federal constitutional precedent for this principle); see also Hensler v. City of Davenport, 790 N.W.2d 569, 581 (Iowa 2010) (noting that U.S. Supreme Court has recognized "that personal choice in matters of family life is a fundamental

liberty interest," and holding that the right to raise one's child also is a fundamental right under the Iowa Constitution).[12]

Certainly, the decision not to bear a child, no less than the decision to bear a child, merits protection as a deeply "personal choice in matters of family life." Hensler, 790 N.W.2d at 581. Pregnancy and childbirth (followed by parenthood or adoption) are uniquely consequential and life-altering in terms of what they demand of a woman physically, medically, emotionally, and practically. Petitioners presented evidence at trial that women forced to carry to term are not only exposed to medical risk and emotional harm, but are also less likely to escape poverty and less likely to formulate and achieve educational, professional, and other life goals. See Part II.B.3.c, above.[13] For that reason, reproductive choice is central to dignity, bodily integrity, and equality, and "implicit in the concept of ordered liberty." King v. State, 818 N.W.2d 1, 26 (Iowa 2012) (internal quotation marks omitted); cf. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 875 (1992) (right to abortion is the "right . . . to be free from unwarranted governmental intrusion into

[12] The Iowa Supreme Court very recently reaffirmed the critical, independent importance of the rights guaranteed to individuals under the *Iowa* Constitution, as well as the crucial role of the courts in protecting these rights. Godfrey v. State of Iowa, 898 N.W.2d 844, 864 (Iowa 2017) ("We begin our discussion by emphasizing the importance of the Bill of Rights in our scheme of government. Unlike the federal constitutional framers who did not originally include a bill of rights and ultimately tacked them on as amendments to the United States Constitution, the framers of the Iowa Constitution put the Bill of Rights in the very first article. . . . Our founders did not cringe at the thought of individual rights and liberties—they embraced them."); see also id. at 865 ("It is the state judiciary that has the responsibility to protect the state constitutional rights of the citizens."); id. at 869 ("The rights and remedies of the Bill of Rights are not subject to legislative dilution as there is no elasticity in the specific guaranty of the Constitution." (internal quotation marks omitted)).

[13] See also Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2315 ("Nationwide, childbirth is fourteen times more likely than abortion to result in death."); Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908, 922 (7th Cir. 2015) (same); N.M. Right to Choose/NARAL v. Johnson, 975 P.2d 841, 855 (N.M. 1998) (noting undisputed evidence "that carrying a pregnancy to term may aggravate pre-existing conditions such as heart disease, epilepsy, diabetes, hypertension, anemia, cancer, and various psychiatric disorders.").

matters so fundamentally affecting a person as the decision whether to bear or beget a child"); Right to Choose v. Byrne, 450 A.2d 925, 934 (N.J. 1982) (holding a woman has a "fundamental right . . . to control her body and destiny. That right encompasses one of the most intimate decisions in human experience, the choice to terminate a pregnancy or bear a child.").

More generally, the Iowa Supreme Court has traditionally afforded strong protection to patient autonomy, as reflected in its law on informed consent for medical care. The Court recently affirmed this principle, including specifically in the context of abortion, by allowing parents to bring a "wrongful birth" claim "based on the physicians' failure to inform them of prenatal test results showing a congenital defect that would have led them to terminate the pregnancy." Plowman v. Ft. Madison Cmty. Hosp., 896 N.W.2d 393, 395 (Iowa 2017). As the Court recognized, patients have the "right to exercise control in making personal medical decisions." Id. at 405.

This Court, therefore, should hold that, under the Iowa Constitution, the right to choose abortion is a fundamental right subject to strict scrutiny review.[14] Hensler, 790 N.W.2d at 580; see also State v. Groves, 742 N.W.2d 90, 93 (Iowa 2007); In re J.L., 779 N.W.2d 481, 490–91 (Iowa Ct. App. 2009); State v. Jorgenson, 785 N.W.2d 708, 715 (Iowa Ct. App. 2009); See generally State v. Ochoa, 792 N.W.2d 260, 267 (Iowa 2010) (because of "independent nature of our state constitutional provisions . . . [t]he degree to which we follow United States Supreme Court precedent . . . depends solely upon its ability to persuade us with the reasoning of the decision"). A statute reviewed under the strict scrutiny standard, "is not presumed constitutional. Rather, the

[14] The Iowa Supreme Court in Sanchez v. State, 692 N.W.2d 812, 820 (Iowa 2005), indicated that abortion is a fundamental right.

State carries the burden of showing that the classification is narrowly tailored to serve a compelling government interest." In re Det. of Williams, 628 N.W.2d 447, 452 (Iowa 2001).

2. The Act cannot survive strict scrutiny.

The Act plainly fails the demanding strict scrutiny standard; indeed, there is *no* record evidence to support the State in meeting its heavy burden under this standard. See Sherman v. Pella Corp., 576 N.W. 2d 312, 317 (Iowa 1998) (under strict scrutiny, classifications affecting fundamental rights are "'presumptively invalid and can be upheld only upon an extraordinary justification'" (citing Personnel Adm'r v. Feeney, 442 U.S. 256, 272 (1979)). The Act states a purpose of "enact[ing] policies that protect all unborn life." S.F. 471, § 5 (2017). Statements by lawmakers asserted, more specifically, that the purpose of the Act is to persuade women seeking an abortion to reconsider their decision.[15] However, the assertion of potential life as compelling cannot be reconciled with each individual's "right to define [her] *own* concept of existence, of meaning, of the universe, and of the mystery of human life," which even the U.S. Supreme Court has recognized as being "[a]t the heart of liberty." Casey, 505 U.S. at 851 (emphasis added).[16] Nor can it be reconciled with her protected "interest in *independence* in making certain kinds of important [personal] decisions." Whalen v. Roe, 429 U.S. 589, 599–600 (1977) (emphasis added);

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[15] One House advocate for the amendment, Rep. Skyler Wheeler, stated, "Our hope with this is that people will see what they have in their womb." See Wheeler: Another Week of Intense Debate, nwestiowa.com (Apr. 8, 2017), http://www.nwestiowa.com/opinion/wheeler-another-week-of-intense-debate/article_4236a06e-1b4c-11e7-a4ac-bf48a7276f04.html. Another, Rep. Sandy Salmon, stated "[t]his will shine the light upon what is really inside the womb of the mother," and that the law would "help a woman consider and make a good, educated decision for herself and her baby." O. Kay Henderson, Iowa House GOP Backs Three-day Waiting Period for Abortions, RadioIowa (Apr. 4, 2017) http://www.radioiowa.com/2017/04/04/iowa-house-gop-backs-three-day-waiting-period-for-abortions/.

[16] The U.S. Supreme Court has never held such an interest to be compelling. See Gonzales v. Carhart, 550 U.S. 124, 145 (2007) (holding that the government has a "legitimate" and "substantial" interest in preserving and promoting fetal life (citing Casey, 505 U.S. at 846, 876)).

see also Gainesville Woman Care, LLC v. State, 210 So. 3d 1243, 1262 (Fla. 2017) ("[S]ocial and moral concerns [including the 'unique potentiality of human life,'] have no place in the concept of informed consent.").

As the Montana Supreme Court recognized in striking down a restriction on abortion, "[i]mplicit in this right of procreative autonomy is a woman's moral right and moral responsibility to decide, up to the point of fetal viability, what her pregnancy demands of her in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation"—*her* values and beliefs, not the state's. Armstrong v. State, 989 P.2d 364, 377 (Mont. 1999). That court further explained that "the State has no more compelling interest or constitutional justification for interfering with the exercise of this right if the woman chooses to terminate her pre-viability pregnancy than it would if she chose to carry the fetus to term." Id.; see also Women of State of Minn. v. Gomez, 542 N.W.2d 17, 31–32 (Minn. 1995) (holding that state's interest in potential life did not become compelling until viability); Planned Parenthood of Middle Tenn. v. Sundquist, 38 S.W.3d 1, 17 (Tenn. 2000), superseded on other grounds by art. I, sec. 36 of the Tennessee Constitution (2014) (same); Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779, 791 (Cal. 1981) ("[A]t least prior to viability, the state may not subordinate a woman's own medical interests or her right of procreative choice to the interests of the fetus."). This Court should join these other courts in finding that, given the deeply personal nature of the abortion decision, the state cannot have a compelling interest in intruding on that decision before viability.

Even were the state's interest in fetal life compelling, the Act would still fail strict scrutiny because the state failed to produce any evidence that requiring two trips to a health center, with at least 72 hours between those visits, is narrowly tailored to that goal. At the outset, it is important to clarify that, even under the less protective federal standard discussed below, the state may not

further its interest in fetal life simply by *hindering* women from seeking an abortion; it may only take steps to ensure that their decision is fully informed (and only if those steps do not unduly burden access). Casey, 505 U.S. at 877. Here, the state has produced no evidence that forcing women to delay their procedure after their ultrasound would help them make more informed decisions.

To the contrary, *Petitioners* offered undisputed expert testimony that the Act would not even *advance* this goal, let alone be narrowly tailored to it. Women already make considered decisions when choosing whether to end their pregnancy. Even before they arrive at the health center, patients have researched and considered their options, and consulted with loved ones. See Part II.B.2, above. Once at the health center, patients receive more information about their options, are offered the opportunity to view their ultrasound, and are given information about the risks of the abortion procedure so that they may make a fully voluntary and informed decision. And if they feel they need more time to make their decision, or the clinic feels they need more time, they reschedule the procedure. Id.[17] There is no evidence whatsoever that a mandatory, blanket, 72-hour additional delay period is even *appropriate*, let alone necessary or helpful. In fact, Petitioners produced expert testimony that this delay would be harmful and contrary to medical ethics. See Part II.B.3.c, above; see Varnum v. Brien, 763 N.W.2d 862, 899 (Iowa 2009) (striking statute where reasoning underlying governmental objective "unsupported by reliable scientific studies").

The Act, moreover, indiscriminately applies to all abortion patients regardless of their circumstances or ability to make an additional trip to the health center. As the evidence presented at trial demonstrated, the Act would only serve to subject all these women to delay, increased

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[17] Nor does the Act serve any medical purpose. Cf. Gainesville Woman Care, 210 So. 3d at 1260 (finding "that the State failed to provide any compelling reason to enhance the informed consent provision or how the current informed consent provision was failing in some way").

health risks, costs, stigma, logistical burdens, and severe stress. See Part II.B.3, above; see also Gainesville Woman Care, 201 So. 3d at 1261 (noting that mandatory 24-hour delay may result in delay "considerably more" than required 24 hours and that abortion was the only medical procedure singled out for delay during informed consent process); Sundquist, 38 S.W.3d at 23–24 (citing evidence "that a large majority of women who have endured waiting periods prior to obtaining an abortion have suffered increased stress, nausea and physical discomfort," as well as evidence of "financial and psychological burdens").

The Act is *grossly* overinclusive in that it applies in cases of fetal anomaly, rape, incest, and domestic violence, as well as when a patient's health is in danger outside of the Act's narrow exceptions. See Sundquist, 38 S.W.3d at 24 (finding "compelling argument" that Tennessee's two-trip, 48-hour waiting period "is especially problematic for women who suffer from poverty or abusive relationships"); Gainesville Woman Care, 210 So. 3d at 1261 (striking a 24-hour mandatory delay requirement and considering evidence that "requiring a woman to make a second trip increases the likelihood that her choice to terminate her pregnancy will not remain confidential, which is particularly important, as amici assert, in the domestic violence and human trafficking context"); cf. Casey, 505 U.S. at 894 (stating Court must not "blind ourselves to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion" due to domestic violence and abuse).

Finally, it hardly can be said that the Act is narrowly tailored when it imposes requirements that are among the strictest in the nation. Indeed, of the states that impose a mandatory delay, the overwhelming majority mandate a 24-hour delay, and even of those, many do not require a second trip; rather, women can receive the state-mandated information by phone or the internet. See

Counseling and Waiting Periods for Abortion, Guttmacher Inst. (2017) https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion.[18]

For all these reasons, the Act fails strict scrutiny review and violates Petitioners' patients' due process right to reproductive freedom.

3. Alternatively, the Act's requirements fail the "undue burden" standard.

In Planned Parenthood of the Heartland, the Iowa Supreme Court declined to reach the issue of whether the decision to end a pregnancy is protected by strict scrutiny under the Iowa Constitution, but held that, at a minimum, it is a right protected by the "undue burden" standard established by the U.S. Supreme Court. Under this standard, while the state has "'important and legitimate interests in preserving and in protecting the health of the pregnant woman' and 'in protecting the potentiality of human life,'" the state may not impose an undue burden on the woman's right to an abortion. Planned Parenthood of the Heartland, 865 N.W.2d at 263 (citing Roe v. Wade, 410 U.S. 113, 162 (1973)). Moreover, any "means chosen by the State to further the interest in potential life must be calculated to *inform* the woman's free choice, *not hinder* it." Casey, 505 U.S. at 877 (emphases added).

More recently, the U.S. Supreme Court in Whole Woman's Health v. Hellerstedt stressed that the undue burden standard requires a court to balance "the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. 2292, 2309 (2016); see also Planned Parenthood of the Heartland, 865 N.W.2d at 268 ("Consistent with United States Supreme Court

[18] The only court to have considered a two-trip, 72-hour mandatory delay restriction, preliminarily enjoined it. See Planned Parenthood of Minn., N.D., S.D. v. Daugaard, 799 F. Supp. 2d 1048 (D. S.D. 2011), claim dismissed on other grounds. Moreover, the Act lacks the tailoring of Texas' and Virginia's 24-hour mandatory delay laws, which not only require far less delay, but also exempt women traveling more than 100 miles to reach a clinic from the extra trip requirement. See Tex. Health & Safety Code Ann. § 171.012(a)(4); Va. Code Ann. § 18.2-76(B).

precedent, we must now weigh the health benefits of [the challenged] rule[s] against the burdens they impose on a woman who wishes to terminate a pregnancy.").[19] In the year following Whole Woman's Health, several federal district courts have applied that standard to laws that the state claimed promoted its interest in fetal life, all finding that the laws failed this balance. See Hopkins v. Jegley, Case No. 4:17-cv-00404-KGB, 2017 WL 3220445, at *21 (E.D. Ark. July 28, 2017) (applying balancing test and rejecting state's argument "that the lesser standard of rational basis review applies when a state regulates to promote respect for unborn life") (internal quotation marks omitted); Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health, No. 1:16-cv-01807-TWP-DML, 2017 WL 1197308, at *6 (S.D. Ind. March 31, 2017) (applying balancing test to law requiring women to obtain ultrasound 18 hours before abortion); Whole Woman's Health v. Hellerstedt (Whole Woman's Health II), 231 F. Supp. 3d 218, 228–29 (W.D. Tex. Jan. 27, 2017) (applying balancing test to law passed for the asserted purpose of "'expressing the State's respect for life'"); W. Ala. Women's Ctr. v. Miller, 217 F. Supp. 3d 1313, 1346–47 (M.D. Ala. 2016) (same); Whole Woman's Health v. Paxton, No. A-17-CV-690-LY, at 8–10 (W.D. Tex. Aug. 31, 2017).

The U.S. Supreme Court also stressed in Whole Woman's Health that, in assessing the benefits as well as the burdens, a court must consider the actual evidence and not merely defer to the state's assertions or speculation. Whole Woman's Health, 136 S. Ct. at 2309 (it "is wrong to

[19] Although Planned Parenthood of the Heartland indicated in dicta that the precise federal test might vary depending on the asserted state interest, id. at 263–64, in fact, as the federal case law cited below recognizes, Casey applied the same balancing test to provisions that purported to advance various interests, including the state's interest in fetal life. The U.S. Supreme Court recently recognized this in Whole Woman's Health, and summarized the "undue burden" standard as requiring generally that courts "consider the burdens a law imposes on abortion access together with the benefits these laws confer." Whole Woman's Health, 136 S. Ct. at 2309 (noting that Casey performed this balancing with respect to a spousal notification provision and a parental notification provision).

equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue"); id. at 2311–12 (noting the absence of evidence demonstrating the existence of a problem the challenged statute would solve); cf. Planned Parenthood of the Heartland, 865 N.W.2d 252 (closely examining the evidence on safety and burden). As Planned Parenthood of the Heartland and other decisions explain, this inquiry is "context-specific" and turns on the evidence and record in the case. See id. at 268–69; Planned Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *23 ("[T]he undue burden analysis is case specific.").

Here, the undisputed evidence at trial established that the burdens imposed on patients by the Act's 72-hour delay and additional trip requirement plainly exceed any purported benefits. As set forth in Part. II.B.2, above, there is no evidence that women are unable to make a considered, informed decision without the Act's intrusive and burdensome requirements.[20] Not only does the Act fail to afford any benefit, but "there is no question the [Act] imposes some burdens that would not otherwise exist and did not exist before the [Act] was adopted," Planned Parenthood of the Heartland, 865 N.W.2d at 267, and these burdens are serious.

In assessing burden, the U.S. Supreme Court in both Casey and Whole Woman's Health identified a wide variety of burdens that should be evaluated in considering the constitutionality of an abortion restriction. For example, the Court has cited (among other burdens) clinic closures; the need for additional travel and its effects on vulnerable populations, such as those with the fewest financial resources; risks to patient confidentiality, particularly in the context of domestic abuse; lack of individualized attention and emotional support; longer wait times and increased

[20] In Whole Woman's Health, the Court held the restriction at issue did not provide any benefits by comparing it to previously-existing requirements and finding that "there was no significant health-related problem that the new law helped to cure." 136 S. Ct. at 2311.

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crowding; and exposure to anti-abortion harassment as imposing constitutionally significant burdens on women seeking abortion. Whole Woman's Health, 136 S. Ct. at 2302, 2312–13, 2318; Casey, 505 U.S. at 885–86, 894; see also Planned Parenthood of Ariz. v. Humble, 753 F.3d 905, 915 (9th Cir. 2014) (considering "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations"); Planned Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *20 (considering additional travel expenses, difficulty in procuring child-care, lost wages, potential loss of employment, and increased risk of disclosure of abortion to abusive partners in undue burden analysis); Strange, 33 F. Supp. 3d at 1357–58.

Courts also "consider evidence that a law delays and deters patients obtaining abortions, and that delay in abortion increases health risks," Humble, 753 F.3d at 915 (internal quotation marks omitted); see also Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *21 (considering evidence on availability of abortion appointments and informed consent appointments at "overburdened" Planned Parenthood health centers).

Here, as explained above, the evidence at trial proved that the Act would impose severe burdens on women seeking an abortion. The Act would require all women to make at least two visits to a health center a minimum of 72 hours apart—to have an ultrasound and receive state-mandated information, and at least 72 hours later, to obtain the abortion. In reality, the Act would cause delays far greater than 72 hours because clinics have scheduling constraints and patients also struggle to schedule appointments and arrange for the necessary transportation and time off from work and other obligations. See Part II.B.3.b, above. Moreover, because of the additional trip, women would be traveling longer distances to access abortion, with almost half of the state's population traveling at least 200 miles roundtrip to obtain a surgical abortion. See Part II.B.3.a, above. This would further delay women. Id. These delays would threaten women's health, increase

the cost of the procedure, and deny many women access to medication abortion, which in turn would pose additional barriers as more women will have to travel farther to access abortion. See Part II.B.3.b, above. For some women, the Act would mean they cannot access abortion at all. Id.

Other courts have recognized that impeding women's access to abortion in these ways imposes an undue burden. See, e.g., Whole Woman's Health, 136 S. Ct. at 2313 (holding abortion restrictions led to scheduling constraints, longer wait times, and increased driving distance, which supported finding of undue burden); Schimel, 806 F.3d at 920 (holding abortion restriction endangered women's health by increasing wait time and causing women to delay abortions); Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *21; Humble, 753 F.3d at 915 (recognizing that state restrictions affecting "the supply of abortion providers and clinics can, at some point, constitute a substantial obstacle to a significant number of women" and describing harms of delaying an abortion); id. at 918 (holding a law that effectively denies some women a medication abortion imposed an "undue burden"). Indeed, the Iowa Supreme Court has already recognized that increased travel distances and an additional trip to a clinic are severe burdens, among other reasons because they can "cause a working mother to potentially miss two to four days of work and incur additional childcare expense" and can result in "a greater possibility that an abusive spouse, partner, or relative could find out the woman is terminating her pregnancy." Planned Parenthood of the Heartland, 865 N.W.2d at 267.

The fact that the Supreme Court upheld a 24-hour mandatory delay requirement "on the record before [it]" in Casey does not alter this balance. Casey, 505 U.S. 885–87. As the Iowa Supreme Court has held, the burden inquiry is "context-specific" and turns on the evidence and record at issue. See Planned Parenthood of the Heartland, 865 N.W.2d at 268–69. While the record in Casey of the benefits and burdens of a one-day delay in Pennsylvania was "troubling" to the

Court and a "close[] question," Casey, 505 U.S. at 885–86, the record here is much more troubling, rendering the balance clearly undue, for at least three reasons.

First, the Act would *triple* the mandatory delay period that was upheld in Casey—from 24 hours to 72 hours—and Petitioners demonstrated that this longer period would be particularly burdensome and would severely delay or prevent women from obtaining abortions for periods of time that would impose risks to their health. Indeed, the Iowa Supreme Court recognized in Planned Parenthood of the Heartland that substantial travel burdens do rise to the level of an undue burden. 865 N.W.2d at 269. As the testimony explains, even for those patients who would be able to obtain an abortion despite the Acts' obstacles, the travel- and delay-related costs imposed by the Act would impose real hardships and constitute a "major financial shock and setback." Collins Report ¶ 43; see also Tr. I at 106:5-12 (Reynolds).

Second, while Casey noted *some* of the burdens also present here, Petitioners presented evidence of significant additional burdens present in this case that were not considered in Casey. Unlike in Casey, which was decided before early medication abortion was available, testimony at trial established that the Act would substantially reduce access to this safe procedure (an effect considered significant by the Iowa Supreme Court in Planned Parenthood of the Heartland, Inc., 865 N.W.2d at 267); see also Humble, 753 F.3d 905 (striking down medication abortion restriction as undue burden); Okla. Coal. for Reprod. Just. v. Cline, 292 P.3d 27 (Okla. 2012) (same). In addition, the evidence showed that because surgical abortion is only provided in two cities in Iowa, the Act would force some women to travel hundreds of miles to obtain an abortion. Compare Rachel K. Jones, et al., Abortion in the United States: Incidence and Access to Services, 2005, 40 Persp. Sexual & Reprod. Health 6, 11 (2008) (at the time of the Casey decision, there were 81 abortion providers in Pennsylvania).

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

Third, Petitioners presented substantial research, published since Casey was decided, showing that mandatory delay laws severely burden women seeking an abortion, and that delaying or preventing women from accessing an abortion has serious, negative effects on their health and well-being. Thus, for example, while "the record evidence" before Casey "show[ed] that in the vast majority of cases, a 24-hour delay does not create an appreciable health risk," 505 U.S. at 885, the evidence presented here at trial demonstrates otherwise. See Part II.B.3.c, above. Finally, unlike in Casey, Petitioners presented evidence that, in fact, the Act would do nothing to further the State's interest. See Part II.B.c, above.

For all of these reasons, like the telemedicine abortion ban recently struck down by the Iowa Supreme Court in Planned Parenthood of the Heartland, the Act "places an undue burden on a woman's right to terminate her pregnancy," 865 N.W.2d at 269, because there is no evidence that it would actually advance any valid state interest and because it unquestionably would make it "more challenging for many women who wish to exercise their constitutional right to terminate a pregnancy in Iowa to do so." Id. at 268.[21]

B. The Act Violates Women's Equal Protection Rights Under the Iowa Constitution.

The evidence at trial also showed that the Act deprives Iowa women of equal protection of the laws in violation of article I, section 1 and article VI, section 1 of the Iowa Constitution, because it singles them out for burdensome restrictions not imposed on patients seeking any other form of health care, including procedures with far greater risks and those for which patients express

[21] In addition to all the harms recognized as substantial and undue in Planned Parenthood of the Heartland, Petitioners' witnesses testified that the Act further harms women by shaming them, indicating that they are not equipped to understand or make decisions about their own pregnancy and are wrong to seek an abortion. Cf. Humble, 753 F.3d at 915 (undue burden standard includes consideration of whether a state restriction "stigmatiz[es] . . . abortion practice").

similar or higher rates of uncertainty before proceeding. Iowa Const. art. I, §§ 1, 6. Indeed, in Planned Parenthood of the Heartland, the Iowa Supreme Court recognized that where the Board had taken different approaches to regulating abortion versus other health-care provided via telemedicine, "'[a]n issue of equal protection of the laws [was] lurking in th[e] case.'" 865 N.W.2d at 269 (quoting Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 790 (7th Cir. 2013)); cf. Plowman, 896 N.W.2d at 418 (Mansfield, J. dissenting) ("An honest appraisal of the [abortion statute] would find that it is intended to *discourage*, not encourage, abortions. The statute sets forth prerequisites for abortion only, not for carrying a pregnancy to term.").

As set forth in Part III.A.1, above, abortion is a fundamental right, and therefore the correct standard of review of Petitioners' equal protection claim is strict scrutiny. See, e.g., In re Det. of Williams, 628 N.W.2d at 452; see also Varnum, 763 N.W.2d at 880; Sanchez v. State, 692 N.W.2d 812, 817 (Iowa 2005). Alternatively, even if this Court were to conclude that abortion is not a fundamental right under the Iowa Constitution, the Act would still be subject to intermediate scrutiny because it facially discriminates against women. Varnum, 763 N.W.2d at 880 (sex-based classifications subject to intermediate scrutiny).

The Act singles out women by requiring a mandatory delay and two-trip requirement for a medical procedure that is only available to women, requirements that do not apply to any other medical procedure. See Cedar Rapids Cmty. Sch. Dist. v. Parr, 227 N.W.2d 486, 493 (Iowa 1975) (striking down regulation that "isolate[d] pregnancy from all other disabilities or physical conditions and ma[de] it subject to the restrictive provisions therein provided," and stating that "such discriminate treatment is linked to sex alone"); see also Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n, 268 N.W.2d 862, 866–67 (Iowa 1978) (finding federal precedent unpersuasive and holding, contrary to that precedent, that "any classification which relies on

pregnancy as the determinative criterion is a distinction based on sex." (citation and internal quotation marks omitted)), superseded by statute on other grounds, Iowa Code § 216.19 (2009);[22] N.M. Right to Choose/NARAL v. Johnson, 975 P.2d 841, 854 (N.M. 1999) (treating abortion restriction as gender-based and applying heightened scrutiny because "[s]ince time immemorial, women's biology and ability to bear children have been used as a basis for discrimination against them," discrimination [is] often justified "on the grounds that it is 'benign' or 'protective' of women." (citation omitted)); cf. Casey, 505 U.S. at 856 (access to legal abortion is necessary to enable women "to participate equally in the economic and social life of the Nation").[23]

Moreover, the Act also discriminates on the basis of sex because it reflects and perpetuates the damaging stereotype that women are not reasonable, competent decision-makers. See Part II.B.3.c; cf. Sundquist, 38 S.W.3d at 23 (in due process context, agreeing that mandatory delay law "insults the intelligence and decision-making capabilities of a woman" and finding law violated state constitution); Casey, 505 U.S. at 918–19 (Stevens, J., concurring in part and dissenting in part) (24-hour mandatory delay "appears to rest on outmoded and unacceptable assumptions about the decisionmaking capacity of women . . . . Just as we have left behind the belief that a woman must consult her husband before undertaking serious matters, so we must

[22] Several other state courts have ruled similarly. See, e.g., Castellano v. Linden Bd. of Educ., 386 A.2d 396, 400 (N.J. Super. Ct. App. Div. 1978), aff'd in relevant part and rev'd in part on other grounds, 400 A.2d 1182 (N.J. 1979)(holding that, contrary to federal precedent, pregnancy-related restriction was sex discrimination because it "imposed on women, without business necessity or other justification, a substantial burden that men need not suffer"); Mass. Elec. Co. v. Mass. Comm'n Against Discrimination, 375 N.E.2d 1192, 1199 (Mass. 1978) (exclusion of pregnancy from disability coverage was sex discrimination because it burdened women economically, disrupted their participation in the workforce, and "reflect[ed] and perpetuat[ed] the stereotype that women belong at home raising a family").

[23] Petitioners presented evidence at trial that women who are forced to carry an unwanted pregnancy to term, among the other harms they suffer, are less likely to escape poverty and less likely to formulate and achieve educational, professional, and other life goals. Part II.B.3.c, above.

reject the notion that a woman is less capable of deciding matters of gravity"); id. at 928–29 (Blackmun, J., concurring in part and dissenting in part) (agreeing); see also N.M. Right to Choose/NARAL, 975 P.2d at 854 (applying heightened scrutiny to abortion restriction after noting long history of legal discrimination against women based on "romantic paternalism"). This paternalistic attitude embodied by the Act also does not comport with the Iowa Supreme Court's strong protection of patient autonomy, see Part III.A.i, above, or with its proud history of advancing the principle of equality.

Under the intermediate scrutiny standard, "the challenged classification [must be] substantially related to the achievement of an important governmental objective." Varnum, 763 N.W.2d at 880. In applying this standard, "the reviewing court must determine whether the proffered justification is exceedingly persuasive," and the court should "scrutinize the means used to achieve that end" and, in particular, "drill down" on the connection between the classification and asserted objective. Id. at 897–98 (internal quotation marks omitted). In addition, the burden of justifying the Act is "demanding and it rests entirely on the *State*." Id. (internal quotation marks omitted and emphasis added).

For the same reasons stated above, Part III.A.ii, the state's asserted interest in potential life cannot be recognized as a "compelling" or "important" interest, or at the very least not as one that the government may advance by intruding to such a degree on women's decision-making. And, for the same reasons set forth in Part III.A.ii, even if the Iowa Constitution permitted Respondents to intrude in such a personal decision, the means Respondents have chosen are not "substantially tailored" to such an interest because they apply to all patients indiscriminately, without justification, and do so in a way that shames women and severely burdens access to constitutionally-protected medical care. See Varnum, 763 N.W.2d at 901 ("A law so

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simultaneously over-inclusive and under-inclusive is not substantially related to the government's objective.").[24]

Thus, this Court should find that the Act violates Petitioners' patients' equal protection rights.

IV. CONCLUSION

The evidence at trial demonstrated that the Act's mandatory delay and additional trip requirements violate Petitioners' and their patients' rights under the Iowa Constitution and the Act should be permanently enjoined.

Respectfully submitted,

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[24] Given the record evidence, the Act is invalid even under the rational basis standard. Under Iowa equal protection jurisprudence, a court determining whether a statute passes the rational basis standard "must first determine whether the Iowa legislature had a valid reason" for the differential classification. Racing Ass'n of Cent. Iowa v. Fitzgerald, 675 N.W.2d 1, 7 (Iowa 2004); see also id. at n.3 (holding the policy reason justifying the classification should be "credible"); Varnum, 763 N.W.2d at 879 (explaining that courts "engage[] in a *meaningful review* of all legislation challenged on equal protection grounds by applying the rational basis test to the facts of each case") (emphasis added); Bierkamp v. Rogers, 293 N.W.2d 577, 581-84 (Iowa 1980) (significant underinclusiveness or overinclusiveness indicates that "the lines drawn do not rationally advance a legitimate government purpose"). The Act's imposition of onerous requirements on no other medical procedure other than abortion in the state serves no credible or valid purpose. The Act only serves to burden patients, including by delaying or preventing them from obtaining abortions.

E-FILED 2017 SEP 08 6:19 PM POLK - CLERK OF DISTRICT COURT

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