SUPREME COURT NO. 17-1579
POLK CO. NO. EQCE081503

**IN THE SUPREME COURT OF IOWA**

**PLANNED PARENTHOOD OF THE HEARTLAND AND JILL MEADOWS, M.D.**,

Petitioners-Appellants,

v.

**KIMBERLY K. REYNOLDS EX REL. STATE OF IOWA AND IOWA BOARD OF MEDICINE**,

Respondents-Appellees.

*APPEAL FROM THE IOWA DISTRICT COURT FOR POLK COUNTY*
*HONORABLE JEFFREY D. FARRELL, DISTRICT COURT JUDGE*

# PETITIONERS/APPELLANTS' BRIEF

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Cin. Women's Servs., Inc. v. Taft, 468 F.3d 361 (6th Cir. 2006)

## II. Whether the Act Violates Petitioners' and their Patients' Equal Protection Rights

### AUTHORITIES

Planned Parenthood of Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015)

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Sanchez v. State, 692 N.W.2d 812 (Iowa 2005)

Cedar Rapids Cmty. Sch. Dist. v. Parr, 227 N.W.2d 486 (Iowa 1975)

Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n, 268 N.W.2d 862 (Iowa 1978)

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## ROUTING STATEMENT

Under Iowa Rule of Appellate Procedure 6.1101(2)(a), (b) and (d), this case warrants retention because it presents a substantial, urgent constitutional question of first impression and broad public importance as to the validity of a statute.

## STATEMENT OF THE CASE

### A. Nature of the Case

For over 40 years, Iowa women who faced an unwanted pregnancy or a medical crisis involving their pregnancy have determined for themselves how much time they need to think through their options. And those who are certain in their decision to end their pregnancy have been able to carry out that decision as soon as they can schedule an appointment at a health center and complete the informed consent and medical screening process.

Section 1 of Senate File 471, to be codified at Iowa Code § 146A (the "Act")—which the district court recognized is "arguably the strictest mandatory waiting period law in the country," App. v.I:338–39—eliminates this option. The Act instead forces all women, regardless of how certain they are, to make an additional and medically unnecessary trip to a health center at least 72 hours before they can obtain an abortion, at which they must have an ultrasound and be given certain state-mandated information intended to promote alternatives to abortion.

The leading national women's health care organization, the American College of Obstetricians and Gynecologists (ACOG), has opposed

mandatory delay laws like the Act because they severely restrict women's access to safe, timely abortion care, thereby jeopardizing their health. App. v.I:543–46, Tr. of Trial Proceedings (July 17, 2017) ("Tr. I"):198:7–201:5. The Act would substantially delay women from obtaining care, exposing them to medical risk, loss of strongly-preferred medical options, severe stress and other emotional harm, loss of confidentiality, burdensome costs, risks to their personal safety, and other dangers and harms. App. v.I:332–333. In some cases, the Act would *prevent* women from obtaining a safe, legal abortion.

The uncontroverted evidence in the record also demonstrated that the Act would impose all these harms without any actual *benefits*. Women *already* deliberate and seek out information before having an abortion. Clinics already provide them with extensive, non-directive information and resources related to all their options. The overwhelming majority of patients are firm in their decision even before they reach the clinic (and most do not opt to view or hear their ultrasound). And those few patients who are uncertain at the time of their appointment already delay their procedure and take the time they need to resolve their uncertainty.

Because the Act would impose serious burdens on women for no factually supported reason, and would single pregnant women out for this ill-treatment, it violates the Due Process and Equal Protection Clauses of the Iowa Constitution.

### B. Procedural History

The Iowa Legislature passed the Act on April 18, 2017, to be effective upon the Governor's signature. The 72-hour mandatory delay provision was added at the last minute with virtually no debate. As soon as they learned that then-Governor Branstad intended to sign the Act, Petitioners-Appellants ("Petitioners") moved for temporary injunctive relief in the district court on May 3. The district court denied relief on May 4, and Petitioners sought a stay from this Court. On May 5, Governor Branstad signed the Act and it took effect. Later that day, this Court temporarily stayed the Act, Order, No. 17-0708 (Iowa May 5, 2017), and on May 9, ordered the parties to hold an expedited final hearing on the merits. App. v.I:250–253. The district court held a trial on July 17 and 18, and entered its Ruling on September 29, upholding the Act and denying Petitioners permanent relief. Petitioners

sought a stay from this Court, which this Court granted on October 23. Order, No. 17-1579 (Iowa October 23, 2017).

## I. STATEMENT OF THE FACTS

### A. The Act

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 and/or hear the ultrasound and/or listen to a description of the fetus based on the ultrasound image, 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"; 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 license discipline by the Board of Medicine ("Board"). Id. § 146A.1(3) Iowa Code § 148.6 (2)(c) (2017).

**B. Evidence Presented at Trial**

At trial, Petitioners presented expert and fact testimony from: Appellant Dr. Jill Meadows, a board-certified obstetrician-gynecologist ("ob-gyn") and the medical director of Planned Parenthood of the Heartland (PPH); Jason Burkhiser Reynolds, a PPH health center manager; 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; and Dr. Susan Lipinski, a board certified ob-gyn who practices in Waterloo and holds leadership positions in both the Iowa Chapter of ACOG and the Iowa Medical Society and who herself does not provide abortions except in emergencies. 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. App. v.II:21–41.

Respondents-Appellees ("Respondents") did not present any live testimony. They submitted written testimony by Mark Bowden, Executive Director of the Board, stating that the Board would promulgate rules implementing the Act (which it has not yet done), 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.

**1. 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. App. v.I:356, Tr. I:11:9–21; App. v.I:448–49 Tr. I:103:22–104:3. Over the past year, PPH provided over 2000 medication abortions and over 1000 surgical abortions in Iowa. App. v.I:363, Tr. I:18:1–8. PPH provides both surgical and medication abortion at two Iowa clinics, in Des Moines and Iowa City. App.

v.I:361, Tr. I:16:9–13. 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 only pills. App. v.I:361, Tr. I:16:9–13 (Meadows); App. v.II:117. The Bettendorf health center will close in the near future. App. v.I:362, Tr. I:17:16–23.[1]

As Petitioners' witnesses testified, women decide to terminate a pregnancy for a variety of familial, medical, financial, and other personal reasons. Nearly one in three women in this country will have an abortion at some point in their lives. App. v.I:483, Tr. I:138:8–11. The majority of these women are mothers who have decided that they cannot parent another child at this time. App. v.II:140; see also App. v.I:483, Tr. I:138:12–21 (Grossman). As Dr. Meadows explained, her patients have considered their own situation and concluded that "[f]or financial, physical, psychological, or

[1] PPH has been forced to close the Bettendorf center, as well as other centers, as a result of additional legislation targeting abortion providers and barring them from providing certain publicly-funded non-abortion family planning services. App. v.I:361, Tr. I:16:14–17:6.

situational reasons they're just not in a place where they can be the parent that they want to be." App. v.I:367, Tr. I:22:22–24.

**2. PPH's Informed Consent Process**

As the uncontroverted trial testimony showed, PPH, like other providers following the standard of care, 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, App. v.I:357, Tr. I:12:14–18, testified that abortion patients are provided with all information necessary for them to understand the risks and benefits of abortion and the alternatives to abortion, and make a fully informed and voluntary decision. App. v.I:364–66, Tr. I:19:21–21:12.

Dr. Meadows and Jason Burkhiser Reynolds, who has provided patient education to hundreds of PPH's abortion patients, App. v.I:448, Tr. I:103:12–21; App. v.I:450–51, Tr. I:105:18–106:1, 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. App. v.I:364–66, Tr.

I:19:21–21:12; App. v.I:459–50, Tr. I:114:17–115:10. 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. App. v.I:365, Tr. I:20:5–20; App. v.I:451, Tr. I:106:16–22; App. v.I:459–60, Tr. I:114:17–115:25; App. v.I:462–63, Tr. I:117:13–118:22. This is the standard of care for other providers as well. App. v.I:495–96, Tr. I:152:11–153:23; App. v.I:497–98, Tr. I:150:19–151:12.[2] Indeed, Respondents failed to present any evidence that a single woman in Iowa has undergone an abortion without first giving informed and voluntary consent.

[2] The only other abortion clinic in Iowa, Emma Goldman in Iowa City, is credentialed by the National Abortion Federation, which requires its members to adhere to similar standards. See Nat'l Abortion Fed'n, 2017 Clinical Policy Guidelines 3–6, available at https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2017-CPGs-for-Abortion-Care.pdf (requiring that each patient "have a private opportunity to discuss issues and concerns about her abortion," and that providers ensure that "appropriate personnel have a discussion with the patient in which accurate information is provided about the procedure and its alternatives, and the potential risks and benefits, and in which "[t]he patient must have the opportunity to have any questions answered to her satisfaction prior to intervention").

As the district court recognized, "[t]he evidence is clear" that Act offers no conceivable benefit to the decision-making of "the vast majority of women" who seek an abortion because these women "have thought hard about the decision by the time they make an appointment[,] . . . have researched their options. . . [and] are not going to change their minds." App. v.I:332.[3] As Dr. Meadows and Mr. Reynolds testified, most women are firm in their decision and ready to have the procedure by the time they *arrive* at

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[3] While acknowledging that most patients are certain by the time of their appointment, the district court overstated the small minority of patients who, despite initially intending to terminate, ultimately change their mind. Citing 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), the court stated that "8 percent of women who appeared for the informational visit changed their mind and took the pregnancy to term." App. v.I:307. That is incorrect. While 8% continued their pregnancy, this percentage included women who were already *inclined* to do so at their informational visit and therefore never changed their minds in the relevant sense. App. v.I:511–12, Tr. I:166:5–167:19. Moreover, this same 8% also included women who carried to term not because they *wanted* to but because of financial or logistical barriers or because the state-mandated delay pushed them past the gestational age when they could find a provider and were comfortable terminating. App. v.I:645, Tr. II:93:5–22. And finally, as Dr. Grossman pointed out and the district court ignored, this same study showed that the percentage of women who truly changed their mind, 2%, was comparable to research from states without any mandatory delay law, indicating that these laws do not persuade women not to have abortions. App. v.I:509–511, Tr. I:164:20–166:2; see generally Roberts, et al., note 2.

the clinic. App. v.I:370–71, Tr. I:25:21–26:5; App. v.I:463–64, Tr. I:118:23–119:7.

To reach that certainty, 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. App. v.I:496, Tr. I:151:16–19. And studies show that patients are as or more certain of their decision to have an abortion than patients presenting for other medical procedures or treatments. App. v.I:499–503, Tr. I:154:4–158:7; App. v.I:509, Tr. I:164:1–8. Most patients, moreover, do not consider an ultrasound relevant to their decision-making process (unsurprisingly, given that most have already carried a prior pregnancy to term). While PPH offers every woman the opportunity to see and/or hear an ultrasound, the majority of patients decline this option. App. v.I:369–370, Tr. I:24:23–25:11.[4]

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[4] As Dr. Grossman discussed, one study of *same-day* voluntary ultrasound viewing showed a small association with carrying to term. However, because that study was non-randomized, it is impossible to determine whether the ultrasound had any effect or whether, conversely, women more inclined to carry to term simply were more likely to opt to view the ultrasound. App. v.I:519–20, Tr. I:174:14-175:12; see also App. v.II:150. At

When a patient is not certain, PPH works with her to identify and consider the values, goals, and circumstances relevant to her decision. App. v.I:371, Tr. I:26:6–19; App. v.I:464, Tr. I:119:8–18. PPH informs her about available resources if she decides to carry to term, such as adoption agencies (including an agency that will meet her in the clinic), prenatal care, public assistance, and other resources. App. v.I:368–69, Tr. I:23:5–24:7; App. v.I:461–62, Tr. I:116:20–117:4; App. v.I:464, Tr. I:119:10–15. Sometimes, the patient education process clarifies for a patient that she wants to continue her pregnancy, and PPH provides her with resources to support that decision. App. v.I:368, Tr. I:23:5–13; App. v.I:464, Tr. I:119:10–15.

If this process does not point a patient to a clear decision, PPH will advise her to take more time to consider her options. App. v.I:371, Tr. I:26:6–19. Thus, while the district court reasoned that the Act "will give women [who are uncertain] an opportunity to collect information and take some additional time before proceeding with an abortion," App. v.I:338, in

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any rate, as the district court acknowledged, this study of same-day ultrasounds does not speak to the question here: whether mandating *delay* after the ultrasound benefits patient decision-making. App. v.I:307.

fact the small minority of women who need that additional time already are encouraged to, and do, take it.[5]

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." App. v.I:503, Tr. I:158:12–16. Petitioners' witnesses', similarly, have heard from patients later who felt they had made the right decision, but had have never had a patient tell them

[5] The district court similarly stated that "there is some research to show that some women change their minds after… being given more time to think about their decision." App. v.I:309. In fact, there is no such study, and all the available evidence indicates the contrary. App. v.I:507–511, Tr. I:162:2–166:2. While the district court cited to studies from Alabama and Utah showing that some women do not return for their second visit, and this number increased after Utah extended its waiting period, these data suggest that women were *prevented*, not *persuaded*. See Kari White, et al., Travel for Abortion Services in Alabama and Delays Obtaining Care, Women's Health Issues, 1, 5 (2017) (noting that women below 100% of the federal poverty line were less likely to return for the second visit and more likely to face greater delays, indicating that the law was burdensome for many women and preventative for some); App. v.I:517, Tr. I:172:4–20 (discussing Utah study); Roberts, et al., note 2 (companion Utah study indicating that number of women who chose to carry to term despite an initial preference for terminating was comparable to that in states with lesser or no mandatory delay periods).

she made the wrong decision or wished she had taken more time to decide. App. v.I:465–66, Tr. I:120:17–121:10; App. v.I:505, Tr. I:160:17–22.

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. App. v.I:400, Tr. I:55:10–23; App. v.I:495–98, Tr. I:150:1–153:7. PPH's informed consent practices are also consistent with Iowa law and the way informed consent is provided for other procedures. Informed consent includes disclosing "information material to a patient's decision to consent to medical treatment," Estate of Anderson ex rel. Herren v. Iowa Dermatology Clinic, PLC, 819 N.W.2d 408, 416 (Iowa 2012), 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. App. v.I:759–60, Tr. of Trial Proceedings (July 18, 2017) ("Tr. II"):207:12–208:6; App. v.II:236–37. Prior to the Act, Iowa did not require a mandatory delay and additional clinic trip for any medical procedure, including abortion.

### 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, Iowa women faced many obstacles in accessing abortion. The majority of PPH's abortion patients, like the majority of abortion patients generally, 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. App. v.I:383–84, Tr. I:38:18–39:21; App. v.I 467, Tr. I:122:2–13; App. v.I:490, Tr. I:145:2–21.

As Dr. Collins explained, low-income women are less likely to have access to a car, especially one suited for a long trip. App. v.I:678–79, Tr. II:126:11–127:23. 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 Iowa's limited public transportation or otherwise make do with limited access to cars or rides. App. v.I:757–58, Tr. II:205:16–206:10; see also App. v.I:382, Tr. I:37:13–14 (Dr. Meadows testifying that PPH "hear[s] on a regular basis how patients have had difficulty in arranging transportation"); App. v.I:303–304 (public transportation is generally not a realistic alternative for Iowa women who live far from a health center and do not have access to a car that can travel far distances). Low income women also often have minimum wage jobs in which there is no sick leave and time off is limited, unpaid (which results in lost wages), and/or difficult to schedule, and can even jeopardize their position. App. v.I:682–684, Tr. II:130:21–132:6; App. v.II:190; App. v.I:682–684, Tr. II:130:18–131:7.

Not only must women manage these constraints, but many of them must do so while traveling far to reach an abortion provider. Abortion access is already limited. App. v.I:487–89, Tr. I:142:1–144:16. 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 Iowa abortion provider. 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. App. v.I:488, Tr. I:143:2–9. The percentage of women who must travel over 50 miles is far higher than the national average of 17%. App. v.I:489, Tr. I:144:10–16.

The Act would severely compound these already-existing obstacles by requiring patients to jump through these same hurdles an additional time. This requirement, in turn, would force women 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. App. v.I:382, Tr. I:37:10–18; App. v.I 490, Tr. I:145:8–21; App. v.I:518, Tr. I:173:9–21; App. v.I:523–24, Tr. I:178:14–179:20; App. v.I:684, Tr. II:132:7–10; App. v.I:685–88, Tr. II:133:4–136:8; App. v.II:124.

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. App. v.I:383, Tr. I:38:18–39:3; App. v.I:471, Tr., I:126:3–18; App. v.I:473–74, Tr. I:128:17–129:14; App. v.I:490, Tr. I:145:15–21; App. v.I:509, Tr. I:164:12–15 (study finding that "low-income women and women who lived more than 20 miles from the clinic were significantly more likely to report that it was hard to get to the clinic for [a state-mandated consultation] visit"); App. v.I:681–82, Tr. II:129:16–130:17 (discussing travel costs); App. v.II:121–22. As the district court recognized, although technically the Act does not prohibit women who live far from PPH from completing the ultrasound closer to home, Petitioners presented undisputed evidence that "women in rural counties do not have the opportunity to get an ob/gyn ultrasound in their home county." App. v.I:301.

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

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. Due

to limited clinician availability and other state restrictions, PPH is already stretched thin and only able to schedule abortion patients 1–3 days a week at some of its health centers, and even less frequently at others. App. v.I:391–92, Tr. I:46:22–47:2; App. v.I:394, Tr. I:49:3–17. As a result, staff already have to schedule patients anywhere from one to two weeks out or longer. App. v.I:392, Tr. I:47:13–21. If PPH had to schedule an extra appointment for each patient, these delays would be even greater and would also affect PPH's non-abortion patients. App. v.I:392–94, Tr. I:47:22–49:17.

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. App. v.I:518, Tr. I:173:1–8; App. v.I:522–23, Tr. I:177:20–178:13. Another study, of Alabama's 24-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. App. v.I:525–26, Tr. I:180:10–181:13; see also App. v.I:526–27, Tr. I:181:19–182:17 (sharp increase in second trimester abortion

rates in Mississippi after 24-hour mandatory delay law went into effect).[6] 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 early as possible," and other research reports similar levels of high preference for prompt care. App. v.I:486, Tr. I:141:3–12; App. v.I:521–22, Tr. I:176:17–177:6. These finding are consistent with Petitioners' experts' clinical experience that patients are firm in their decisions and want to end their pregnancy as quickly as possible. App. v:I:397–98, Tr. I:52:18–53:3; App. v.I:548, Tr. I:203:1–7.

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 and many of PPH's patients present near the end of this time-window. App. v.I:373, Tr. I:28:11–14; App. v.I:375, Tr.

[6] The district court ignored the evidence presented at trial that a significant percentage of Iowa women are likely to be delayed *beyond* two weeks.

I:30:10–21.[7] This would harm women, many of whom strongly prefer medication abortion. For example, for sexual assault survivors, medication abortion can feel less invasive and, for that reason, may be far easier to undergo. App. v.I:373, Tr. I:28:15–24; App. v.I:467–68, Tr. I:122:14–123:1; App. v.I:484–86, Tr. I:139:3–141:12. For some women, this non-surgical method is medically indicated, App. v.I:373–74, Tr. I:28:25–29:6, by pushing some of these women beyond the ten-week limit, the Act would force them to undergo a riskier surgical procedure, App. v.I:375, Tr. I:30:22–31:5. And even for those women who could still access medication

[7] The district court questioned that woman would lose access to medication abortion based on its speculation that women could just adapt by scheduling their first visit earlier. App. v.I:311; But see App. v.I:333 (acknowledging that the law "could" have that effect). In fact, the evidence was clear that the Act *would* prevent many women from accessing medication abortion. App. v.I:397–98, Tr. I:52:18–53:3; App. v.I:488, Tr. I:141:3–12; App. v.I:521–22, Tr. I:176:17–177:6; App. v.I:548, Tr. I:203:1–7. And, while the district court assumed that women currently are "voluntarily" scheduling procedures close to ten weeks, App. v.I:310–11, the evidence indicates that in fact they do so because it took them some time to realize they were pregnant, make their decision, and overcome the logistical barriers to seeking care. App. v.I:376–77, Tr. I:31:21–32:20; App. v.I:467, Tr. I:122:2–13; App. v.I:490, Tr. I:145:2–21; cf. Planned Parenthood of Ariz. v. Humble, 753 F.3d 905, 915 (9th Cir. 2014) (noting that many women have a narrow window for accessing a medication abortion once they reach the clinic because they have already been delayed by "practical considerations, such as the frequency with which clinics can see patients and the difficulties women face in obtaining time off from work or transportation to a clinic").

abortion, forced delay would be harmful because medication abortion is more effective the earlier it is initiated, and if it fails, women have to obtain further care. App. v.I:374–75, Tr. I:29:12–30:9.

Because surgical abortion is only available in two Iowa cities (Des Moines and Iowa City), women who were pushed past the cut-off for medication abortion (which is also available in Ames, Cedar Falls, and Council Bluffs) would often have to travel significantly farther to access abortion (in addition to having to make the additional ultrasound trip required by the Act). App. v.I:528–39, Tr. I:183:15–184:12. Thus, for example, a patient in Council Bluffs who lost her chance to have a local medication abortion 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. By depriving women of access to a medication abortion closer to home, the Act is likely to delay women still further and to prevent some women from obtaining an abortion. App. v.I:507, Tr. I:162:2–15; App. v.I:757–58, Tr. II:205:16–207:8. 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. App. v.I:529, Tr. I:184:13–21; App. v.I:530–34, Tr. I:185:1–189:9; see also Planned Parenthood Se., Inc. v. Strange, 33 F. Supp. 3d 1330, 1356 (M. D. Ala. 2014) (reviewing and crediting this evidence); Planned Parenthood of Ariz. v. Humble, 753 F.3d 905, 916 (9th Cir. 2014) (immediately after an Arizona restriction ended abortion services in an underserved area of the state, that area saw a 31% decrease in abortion rate). W. Ala. Women's Ctr. v. Miller, 217 F. Supp. 3d 1313, 1331 (M.D. Ala. 2016).

The evidence also shows that, distance aside, the requirement of *multiple visits*, on its own, will prevent 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. App. v.I:645–46, Tr. II:93:8–94:4; App. v.I:524–25, Tr. I:179:21–180:4 (discussing Roberts, et al., note 2); see also App. v.I:515, Tr. I:170:1–21 (citing research indicating that patients were delayed, and some prevented, after Texas's mandatory delay went into effect); Part I.B.3.d, below (Act likely to prevent some domestic violence victims from accessing abortion);

App. v.I:658, Tr. II:106:1–21; App. v.II:174–75, 196–97(Act would impose costs that, for some low-income women, would be prohibitive); App. v.I:311 (indicating that the Act would prevent some women from terminating for medical indications that arose later in their pregnancy).[8]

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

As the trial testimony showed, by delaying most women for a week or often longer, the Act would expose them to health risks and other harms. While abortion is an extremely safe procedure, its risks increase as the pregnancy advances, even week-to-week. App. v.I:376, Tr. I:31:2–5; App. v.I:532, Tr. I:187:3–10. A second trimester abortion, while still safer than childbirth, is 8–10 times riskier than a first-trimester abortion. App. v.I:609, Tr. II:57:4–11.[9] Mandatory delays also cause women significant stress; make them feel stigmatized and powerless; jeopardize the confidentiality of their

[8] Entirely disregarding this evidence (as well as its own acknowledgement that the Act might prevent women for whom a medical indication for abortion arises later in pregnancy) and citing no evidence to the contrary, the district court erroneously concluded that the Act would not prevent any women from accessing abortion. App. v.I:311.

[9] The district court's opinion incorrectly states that Dr. Grossman "did not testify to the degree of increase" in medical risk from delayed abortion. App. v.I:310.

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. App. v.I:396–97, Tr. I:51:24–52:15; App. v.I:486, Tr. I:141:14–23; App. v.I:495, Tr. I:150:6–15; App. v.I:521–24, Tr. I:176:6–179:20; see also App. v.I:469–71, Tr. I:124:2–126:15 (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); App. v.I:508, Tr. I:163:13–22 (in one study, 31% of patients reported that "waiting period had a negative effect on their emotional well being").

Additionally, by delaying women, the Act would impose substantial costs on them (most of whom are low-income) because abortion becomes more medically complex, and therefore costly, later in pregnancy. App. v.I:507, Tr. I:162:8–15; App. v.I:376, Tr. I:31:15–20 (costs can more than double); App. v.II:127. Those increased costs would come on top of additional clinic-related costs from extra appointments, App. v.I:395, Tr. I:50:19–24, as well as increased travel-related costs. As explained above,

these costs would be a "major financial shock and setback" for some of PPH's low-income patients, who either would not be able to afford them or would only manage to afford them by taking on debt and/or skimping on food and other basic necessities. App. v.II:196; App. v.I:658, Tr. II:106:5–21; App. v.I:699–702, Tr. II:147:23–150:12; see also App. v.I:492–493, Tr. I:147:17–148:21 (even without significant state-imposed barriers, low-income patients already forego these necessities to pay for the procedure and related costs).

As set forth above, some women would be unable to overcome these burdens and therefore unable to access a safe legal abortion. In addition to being effectively denied a right that is central to both bodily and decisional privacy, these women and their families would face a range of other harms. Childbirth poses far greater health risks than abortion. See App. v.II:141–142; App. v.I:543, Tr. I:189:12–16. 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. App. v.I:543–540, Tr. I:189:17–195:19. 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. App. v.I:540–543, Tr. I:195:20–198:6.

Because mandatory delay laws like the Act harm women's health, they are opposed by ACOG. App. v.I:543–546, Tr. I:198:7–201:5. 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. App. v.I:380, Tr. I:35:14–19. The Act violates other principles of medical ethics as well: the requirements that providers do their patients no harm and preserve patient autonomy. App. v.I:400–401, Tr. I:55:10–56:12; App. v.I:505–506, Tr. I:160:23–161:11; App. v.I:548–549, Tr. I:203:18–204:1; App. v.I:737–738, Tr. II:185:18–186:3.

Finally, the Act harms women because it perpetuates the false gender stereotype that they do not understand the nature of the abortion procedure,

have not thought carefully about their decision, and/or are less capable of making an informed decision about their health care than men. App. v.I:381, Tr. I:36:5–11; App. v.II:133–134. The Act also stigmatizes women seeking abortions and sends the harmful message that they are incompetent decision-makers. App. v.I:381, Tr. I:36:5–11; App. v.I:400–401, Tr. I:55:19–56:12; App. v.II:133–134.

**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. The Act's requirements threaten women's confidentiality, and would endanger women who are being abused or are at risk for abuse. App. v.II:24–25, 40; see also App. v.I:472, Tr. I:127:1–17. Studies show the lifetime cumulative rate of abuse for women seeking abortions to be at 27–31%. App. v.II:26 n.2. According to the CDC, 31.3% of Iowa women (or 360,000 women) have experienced rape, physical violence, and/or stalking by an intimate partner. App. v.II:26–27. 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. App. v.II:26 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 would find it extremely difficult, or impossible, to arrange and attend an additional, medically-unnecessary abortion-related health visit. App. v.II:30–31, 33–34; App. Av.I:490–492, Tr. I:145:17–147:6. 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. App. v.I:467 Tr. I:122:4–13; App. v.I:472, Tr. I:127:1–17. 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.

App. v.I:559, Tr. II:7:2–9.

By making it harder for abused women to obtain an abortion, the Act would also make it harder for them to escape that abuse. App. v.II:31–32 (carrying unwanted pregnancy to term can 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 compromising their privacy and by making it harder or impossible for them to end an unwanted pregnancy. App. v.II:38.

The Act also would especially harm women whose pregnancies are the result of rape. For these women, the Act's delay and extra trip requirements would inflict particular psychological harm and could even prevent them from accessing care altogether. App. v.II:32–34, 39–40; App. v.I:546, Tr. I:201:9–202:3. In Dr. Meadows' words, 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." App. v.I:397–398, Tr. I:52:16–53:3. Moreover, 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. App. v.I:548, Tr. I:203:1–7. 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). The Act would impose serious medical risks on 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, renal disease, or premature rupture of the membranes. App. v.I:399, Tr. I:54:7–19; App. v.I:546, Tr. I:201:18–22; App. v.I:558–559, Tr. II:6:18–7:1, App. v.I:760–761, Tr. II:208:15–209:3. As the district court acknowledged, because some dangerous conditions "only develop or become known later in pregnancy" and because the legislature has banned abortion after 20 weeks, the Act would not only delay but even prevent some women from obtaining medically necessary care until their condition actually worsens into a life-threatening situation. App. v.I:311.

Likewise, for women who make the painful decision to terminate a wanted pregnancy after receiving an unexpected diagnosis of a severe or lethal 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 sees this situation as "an issue of addressing their mental health needs by trying to perform the abortion as quickly as possible." App. v.I:562, Tr. II:10:10–23. Contrary to that clinical imperative, the Act's requirements would prolong that painful and anxious experience, and would interfere with Petitioners' ability to exercise medical judgment and provide compassionate care to these patients. App. v.I:399, Tr. I:54:24–55:23; App. v.I:547, Tr. I:202:4–13; App. v.I:207, Tr. II:207:9–19.

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. App. v.I:377–378, Tr. I:32:21–33:6; App. v.I:398, Tr. I:53:4–11; App. v.I:761–762, Tr. II:209:20–210:10. 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. App. v.I:762, Tr. II:210:11–16. 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. App. v.I:762, Tr. II: 210:17–20.

## II. ARGUMENT

### A. Error Preservation and Standard of Review

Error was preserved for Petitioners' due process and equal protection claims. Petitioners argued, and the district court considered, that the Act violates Petitioners' patients' due process rights. App. v.I:802–815; App. v.I:314–339. Petitioners also argued, and the court also considered, that the Act violates their patients' equal protection rights. App. v.I:815–819; App. v.I:339–340. The standard of review for both of these claims is de novo, with respect both to that court's legal conclusions and to the general facts it found in reaching those conclusions. See Varnum v. Brien, 763 N.W.2d 862, 881 (Iowa 2009) (citing need to "rely on the most compelling data," and considering all of the material offered by the parties, including evidence excluded by the district court, as part of de novo reviewing standard in

summary judgment context); Anderson v. Low Rent Housing Comm'n of Muscatine, 304 N.W.2d 239, 246 (Iowa 1981) (applying de novo standard of review "to examination of the facts presented to the trial court in order to determine whether a constitutionally protected liberty interest was violated"); State v. McKnight, 511 N.W.2d 389, 391 (Iowa 1994) (noting that when "constitutional questions are raised, [the court's] review is de novo in light of the totality of the circumstances"); See also Equal. Found. v. City of Cin., 54 F.3d 261, 265 (6th Cir. 1995), vacated and remanded on other grounds, 518 U.S. 1001 (1996) (holding that when a lower court's findings include those designed to support constitutional facts, the findings are reviewed de novo).

### B. The Act Violates Women's Due Process Rights

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

This Court has recognized that abortion is a right protected under the Iowa Constitution. Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med. ("PPH I"), 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). In PPH I, this Court noted that several

state courts have afforded this right greater protection under their state constitutions than the "undue burden" standard applied under under the U.S. Constitution. 865 N.W.2d at 262 n.2. However, this Court did not reach the question of whether the Iowa Constitution affords such heightened protection because the restriction PPH challenged failed the federal standard. Id. at 263; cf. State v. Baldon, 829 N.W.2d 785, 791 (Iowa 2013) (explaining that, for claims brought under the Iowa Constitution, federal jurisprudence concerning "fundamental, civil, or human right[s]… makes for an admirable floor, but is certainly not a ceiling").

More recently, this Court recognized 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 held "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).

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; cf. State, Dep't of Health & Social Servs v. Planned Parenthood of Alaska, Inc., 28 P.3d 904, 913 (Alaska 2001) ("[A] woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice."). 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. Women forced to carry to term are not only exposed to medical risk and emotional harm, but are also less likely to escape poverty or domestic violence and less likely to formulate and achieve educational, professional, and other life goals. See Part I.B.3.c, above.

For these reasons, 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).

As now-Justice Ginsburg put it, "in the balance is a woman's autonomous charge of her full life's course—…her ability to stand in relation to man, society, and the state as an independent, self-sustaining, equal citizen." Ruth B. Ginsburg, Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade, 63 N.C. L. Rev. 375, 383 (1985); see also 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."); See Women of the State of Minn. v. Gomez, 542 N.W.2d 17, 27 (Minn. 1995) ("[W]e can think of few decisions more intimate, personal, and profound than a woman's decision between childbirth and abortion…[which] governs whether the woman will undergo extreme physical and psychological changes and whether she will create lifelong attachments and responsibilities."); Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice, 948 P.2d 963, 968 (Alaska 1997) ("[A] woman's control of her body, and the choice whether or when to bear children, involves the kind of decision-making that is necessary for civilized life and ordered liberty." (internal quotation and alteration marks omitted)).

More generally, this 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," including the decision to end a pregnancy. Id. at 405.

This Court, therefore, should join the high courts in numerous other states that have found that the right to choose abortion warrants greater protection than has been afforded under the federal Constitution: Alaska, California, Connecticut, Florida, Indiana, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Tennessee, and West Virginia. Gomez, 542 N.W.2d 17 (Minn. 1995); Planned Parenthood League of Mass., Inc. v. Attorney Gen., 677 N.E.2d 101, 103–04 (Mass. 1997); Armstrong v. State, 989 P.2d 364 (Mont. 1999); Planned Parenthood of The Great Nw. v. State,

375 P.3d 1122 (Alaska 2016); Gainesville Woman Care, LLC v. State, 210 So.3d 1243 (Fla. 2017) (enjoining 24-hour mandatory delay law); Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797 (Cal. 1997); Planned Parenthood of Cent. N. J. v. Farmer, 762 A.2d 620 (N.J. 2000); Women's Health Ctr. of W. Va. Inc., v. Panepinto, 446 S.E.2d 658 (W. Va. 1993); Planned Parenthood of Middle Tenn. v. Sundquist, 38 S.W.3d 1 (Tenn. 2000), superseded by constitutional amendment by art. I, sec. 36 of the Tennessee Constitution (2014); Humphreys v. Clinic for Women, Inc., 796 N.E.2d 247 (Ind. 2003); N.M. Right to Choose/NARAL v. Johnson, 975 P.2d 841 (N.M. 1998); Doe v. Maher, 515 A.2d 134 (Conn. Super. Ct. 1986).

As this Court has made plain, these decisions are just as relevant to this Court's analysis as federal precedent. See generally State v. Ochoa, 792 N.W.2d 260, 267 (Iowa 2010) (federal precedent "is no more binding upon our interpretation of... [the Iowa Constitution] than is a case decided by another state supreme court under... [an analogous] provision of that state's constitution," and the force of any federal or other-state precedent "depends solely upon its ability to persuade us with the reasoning of the decision").

The district court noted some of these state decisions, but found them unpersuasive because in some of these states, the state constitution expressly recognizes a right to privacy (though not to abortion). The district court overlooked that, in several of these states, the court's conclusion was not based on an explicit state constitutional privacy protection. It also ignored that Iowa's constitution *does* have language indicating stronger liberty and equality protections than in the federal constitution. Compare Iowa Const. art. I § 1 ("All men are, by nature, free and equal, and have certain inalienable rights - among which are those of enjoying and defending life and liberty, acquiring, possessing and protecting property, and pursuing and obtaining safety and happiness."), with Farmer, 762 A.2d at 629 (based on virtually identical language in the New Jersey Constitution, holding that that constitution was "more expansive… than that of the United States Constitution" and "incorporates within its terms the right of privacy and its concomitant rights, including a woman's right to make certain fundamental choices" (internal quotation marks and alterations omitted)), and Panepinto, 446 S.E.2d at 664 (same for West Virginia Constitution); cf. Right to Choose, 450 A.2d at 933 ("By declaring the right to life, liberty and the

pursuit of safety and happiness, [state constitution] protects the right of privacy.").

Moreover, this Court already recognizes privacy as a fundamental right under the Iowa Constitution. The relevant questions here are whether that right includes a woman's right to choose abortion and, if so, whether there is any compelling reason for this Court to depart from its general approach to fundamental rights and apply something less than strict scrutiny. The state decisions cited above—both those in states with an explicit constitutional privacy protection and those in states without one—are persuasive authority for the conclusions that Petitioners urge this Court to reach: 1) that abortion is a core privacy right, and 2) that it should be treated like other fundamental rights under the Iowa Constitution.[10]

[10] Even where courts have cited state constitutional language different from the United States Constitution as part of their analysis, they generally have not relied on those differences for their holding but rather have considered the real-world significance of restrictions on abortion. See, e.g., N.M. Right to Choose, 975 P.2d at 852 ("We do not base our analysis on a mere textual difference between the federal and state constitutions."); Armstrong, 989 P.2d at 378 (invoking not only the text of the state constitution but also political and moral philosophy and state's "historical tradition of protecting personal autonomy and dignity").

**2. The Act cannot survive strict scrutiny.**

Assuming this Court adopts that approach, the Act would be subject to the demanding strict scrutiny standard, which it cannot satisfy. A statute reviewed under the strict scrutiny standard, "is not presumed constitutional. Rather, the 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). See Sherman v. Pella Corp., 576 N.W. 2d 312, 317 (Iowa 1998) (under strict scrutiny, restrictions are "'presumptively invalid and can be upheld only upon an extraordinary justification'" (citing Pers. Adm'r v. Feeney, 442 U.S. 256, 272 (1979)). There can be no question that, here, Respondents have failed to satisfy that burden.

The Act's stated purpose is to "protect all unborn life." S.F. 471, § 5 (2017). Lawmakers asserted, more specifically, the purpose of persuading women seeking an abortion to reconsider their decision. 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." Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) (right to abortion is the "right . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child"). Nor can it be reconciled with a woman's protected "interest in *independence* in making certain kinds of important [personal] decisions." Whalen v. Roe, 429 U.S. 589, 599–600 (1977) (emphasis added).

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, 989 P.2d at 377. 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 Gainesville Woman Care, LLC 210 So. 3d at 1262 (Fla. 2017) ("[S]ocial and moral

concerns [including the 'unique potentiality of human life,'] have no place in the concept of informed consent."); Gomez, 542 N.W.2d at 31–32 (holding that state's interest in potential life did not become compelling until viability); Sundquist, 38 S.W.3d 1 at 17, (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."); cf. Casey, 505 U.S. at 916 (Stevens, concurring in part and dissenting in part) ("Decisional autonomy must limit the State's power to inject into a woman's most personal deliberations its own views of what is best."). This Court, similarly, should find that, given the deeply personal nature of reproductive decisions, the state cannot have a compelling interest in intruding on these decisions before viability.

Even were the state's interest in embryonic or 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, actually advances that goal (let alone that it is narrowly tailored to it). At the outset, it bears emphasis that, even under the less

protective federal standard, the state may not further its interest in potential life simply by *hindering* women from seeking an abortion; it may only take steps to ensure that their decision is 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 by at least 72 hours would help them make more informed decisions.

Petitioners offered undisputed expert testimony to the contrary. 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 I.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.

Most women are firm in their decision and ready to have the procedure by the time they arrive at the clinic. See Part I.B.2, above. If a patient feels she needs more time, or the clinic feels she needs more time,

she reschedules the procedure. Id. Thus, there is no evidence whatsoever that a mandatory, blanket, 72-hour additional delay period is helpful. Gainesville Woman Care, LLC, 210 So.3d at 1261 (no evidence that mandatory delay needed because "a woman can already take all of the time she needs to decide whether to terminate her pregnancy, both before she arrives at the clinic and after she receives the required counseling information"); see Varnum v. Brien, 763 N.W.2d 862, 899 (Iowa 2009) (striking statute where reasoning underlying governmental objective "unsupported by reliable scientific studies"). In fact, Petitioners' experts opined that this delay would be harmful and contrary to medical ethics. See Part I.B.3.c, above; Gainesville Woman Care, LLC, 210 So.3d at 1258 ("The Mandatory Delay Law… turns informed consent on its head, placing the State squarely between a woman who has already made her decision to terminate her pregnancy and her doctor who has decided that the procedure is appropriate for his or her patient.")

Nor could the Act possibly be deemed narrowly tailored. App. v.I:332–333, 338 (agreeing that "there is no question that the Iowa legislature could have written the Act to be less restrictive"). The Act

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 cause all these women delay, increased health risks, costs, stigma, logistical burdens, and severe stress. See Part I.B.3, above; see also Gainesville Woman Care, LLC, 210 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* over-inclusive in that it applies in cases of rape, incest, domestic violence, and fetal anomalies, 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 (enjoining 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"). As the district court acknowledged, "[t]here is no question that" the Iowa legislature could have tailored the Act to reduce burdens on "poor women," "women who must travel longer distances to a clinic," and women with medical indications for abortion. App. v.I:338. The legislature also could have, yet chose not to, "provided an exception for rape and victims of domestic abuse," id., despite the obvious and egregious harms the Act imposes on these women.

Finally, the Act can hardly be 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. The Act also lacks any exemption for women who live far from health centers, unlike those in Texas' and Virginia's 24-hour mandatory delay laws. See Tex. Health & Safety Code Ann. § 171.012(a)(4); Va. Code Ann. § 18.2-76(B).

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

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

In PPH I, this 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 protected by the "undue burden" standard established by the U.S. Supreme Court. Under this standard, while the state may regulate abortion to promote women's health and protect the potential life of the embryo or fetus, the state may not impose an undue burden on the woman's right to an abortion. PPH I, 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 ("WWH"), 136 S. Ct. 2292 (2016) 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. at 2309 (2016); see also PPH I, 865 N.W.2d at 268 ("Consistent with United States Supreme Court 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.").

The district court concluded that the balancing test applied in WWH does not apply to laws, like the Act, that purport to advance a state interest in potential life. App. v.I:323–324.[11] That is incorrect. In applying the undue burden standard, the Supreme Court has not distinguished between the interests in patient health and potential life. Casey described a unitary standard (undue burden) that applies regardless of the state's asserted interest. See Casey, 505 U.S. at 877 ("[A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be

[11] PPH I also indicated in dicta that the precise federal test might vary depending on the asserted state interest. 865 N.W.2d at 263–64.

considered a permissible means of serving its legitimate ends."); id. at 887–901 (applying this standard to both the spousal notification requirement, which the state defended as furthering potential life, and the recordkeeping and reporting requirements, which the state defended as promoting women's health).

And although WWH concerned restrictions purportedly related to the interest in patient health, the Supreme Court in no way limited it recitation of the undue burden standard to that interest. Rather, in explaining that "[t]he rule announced in Casey . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer," the WWH Court explicitly noted that Casey "perform[ed] this balancing with respect to a spousal notification provision" and "with respect to a parental notification provision"—two provisions that were defended as furthering the state's interest in potential life. 136 S. Ct. at 2309.

In the year following WWH, several federal district courts have recognized that this is a unitary standard and applied it to laws that the state claimed promoted potential life. 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. 1:17-cv-00690-LY, 2017 WL 3814835 at *4 (W.D. Tex. Aug. 31, 2017) (same).[12]

Under this test, "the state has the burden of demonstrating a link between the legislation it enacts and what it contends are the state's interests." Hopkins, 2017 WL 3220445, at *22 (citing Casey, 505 U.S. 833,

[12] While the district court suggested WWH is somehow limited to restrictions that would close clinics, App. v.I:338, these cases make plain that it is not.

112 S.Ct. 2791); see generally WWH, 136 S. Ct. at 2309 (it "is wrong to 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 any evidence from the state demonstrating a problem the challenged statute would solve); cf. PPH I, 865 N.W.2d 252 (closely examining the evidence on safety and burden). Moreover, courts "may take into account the degree to which the restriction is over-inclusive or under-inclusive, and the existence of alternative, less burdensome means to achieve the state's goal. Hopkins, 2017 WL 3220445, at *22 (citing WWH, 136 S.Ct. at 2315).

The district court appears to have construed the undue burden test as requiring a showing that the challenged restriction will, in effect, be not just harmful but *insurmountable*. See App. v.I:336 (finding that the evidence did not show "a substantial obstacle" because it did not show that "mandatory delay laws cause women to give up their decision to choose to have an abortion"). Not only did the district court ignore factual evidence that the Act will in fact prevent some women altogether, see Part I.B.3.b, but this

standard also misunderstands federal precedent. In assessing burden, and in contrast to the district court's approach here, the U.S. Supreme Court in both Casey and WWH 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 crowding; and exposure to anti-abortion harassment as imposing constitutionally significant burdens on women seeking abortion. WWH, 136 S. Ct. at 2302, 2312–13, 2318; Casey, 505 U.S. at 885–86, 894.

Lower federal courts have followed this approach, considering a range of relevant burdens. See Humble, 753 F.3d at 915 (9th Cir. 2014) (considering loss of access to medication abortion, health risks from delayed abortion, as well as "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations"); Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908,

920 (7th Cir. 2015) (holding abortion restriction endangered women's health by increasing wait time and causing delay); 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); Strange, 33 F. Supp. 3d at 1357–58.

Here, the undisputed evidence at trial established that the Act imposes burdens far weightier than any purported benefits. As set forth in Part. I.B.2, above, there is no evidence that women are unable to take the time they need to make a considered, informed decision without the Act's intrusive and burdensome requirements. See also EMW Women's Ctr. v. Beshear, No. 3:17-cv-16-DJH, 2017 WL 4288906 at *11 (W. D. Ky. Sept. 27, 2017) (finding that mandatory ultrasound law "ha[s] not dissuaded any women from undergoing an abortion"). Not only does the Act fail to afford any actual benefit, but it is strikingly over-inclusive even in relation to its purported benefits, and "there is no question the [Act] imposes some burdens that would not otherwise exist and did not exist before the [Act] was

adopted," PPH I, 865 N.W.2d at 267, and these burdens are serious. See Part I.B.3, above.

Indeed, this 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." PPH I, 865 N.W.2d at 267. Thus, the Act fails the undue burden standard.

That Casey upheld a 24-hour mandatory delay requirement "on the record before [it]" does not alter this conclusion. Casey, 505 U.S. 885–87. As this Court has held, the burden inquiry is "context-specific" and turns on the evidence and record at issue. See PPH I, 865 N.W.2d at 268–69; Humble, 753 F.3d at 916 (distinguishing Casey, and noting that "[a]lthough there may be cases in which additional travel time does not in itself rise to the level of an undue burden, this factor must be evaluated on a case-by-case basis and balanced against the strength of the state's interest"); Planned Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *23 (same). Even

Casey found the burdens imposed by Pennsylvania mandatory delay law "troubling," and its constitutionality a "close[] question," Casey, 505 U.S. at 885–86; the record here is much more troubling, rendering the balance clearly unconstitutional, for at least four reasons.

First, the Act would impose triple the mandatory delay period that was upheld in Casey, and the evidence at trial confirmed the obvious fact that a longer required delay is more burdensome. App. v.I:517, Tr. I:172:8–20; App. v.I:518, Tr. I:173:18–21 (noting research that after Utah extended its waiting period from 24 to 72 hours, fewer patients made it back for the second visit, and that patients reported that the longer period forced them to make disclosures they otherwise could have avoided); App. v.I:762, Tr. II:210:11–16 (72 hour delay more likely to push women with a severe fetal anomaly past Iowa's gestational cut-off); App. v.I:760–761, Tr. II:208:15–209:19 (Act puts physicians in the position of either risking their license to provide urgently-needed care to patients with a pregnancy complication or delaying care for 72 hours in a situation where risk increases "the longer we wait")).

Second, while Casey noted some of the burdens also present here, Petitioners presented evidence of significant additional burdens not considered in Casey. For example, whereas Casey was decided before early medication abortion was available, Petitioners established that the Act would substantially reduce access to this safe procedure (an effect considered significant by this Court in PPH I, 865 N.W.2d at 267); see also Humble, 753 F.3d at 915 (striking down medication abortion restriction as undue burden, and noting evidence that "some women so strongly prefer medication abortion, and so object to surgical abortion, that they will forego abortion entirely if they cannot obtain a medication abortion"); 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 Part I.B.1 (surgical abortion only available in two cities in Iowa), with 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). Petitioners also

presented extensive evidence that mandatory delay laws harm and endanger patients who are at risk for domestic abuse, whereas Casey's holding "reli[ed] on the paucity of the record [in that case] concerning how the in-person informed-consent requirement affected abused women." Cin. Women's Servs., Inc. v. Taft, 468 F.3d 361, 372 (6th Cir. 2006).[13]

Third, Petitioners presented substantial research, published since Casey (and other federal cases upholding shorter waiting periods than Iowa's) were decided, showing that mandatory delay laws do not persuade women not to have an abortion. Rather, they severely burden women seeking an abortion, including imposing serious, negative effects on their health and well-being. See Part I. B.3.c, above. Thus, for example, while "the record evidence" before Casey "show[ed] that in the vast majority of

[13] In upholding the Act despite "concerning" evidence, absent in Casey, that the Act would severely harm domestic violence victims, the trial court relied on the fact that the Sixth Circuit did so in Taft, a 24-hour mandatory delay case. App. v.I:334–335. But that decision applied an incorrect version of the "undue burden" standard, similar to the Fifth Circuit version rejected by the Supreme Court in WWH, and certainly one that should not be persuasive to this Court. Specifically, in Taft, the court required plaintiffs to demonstrate that the challenged restriction "renders it nearly impossible for the women actually affected by an abortion restriction to obtain an abortion." 468 F.3d at 373.

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.

Finally, as the district court acknowledged here (and then ignored in its legal analysis), whereas Casey relied on lower court interpretations to find that the emergency exception to Pennsylvania's delay requirement would cover common complications "such as preeclampsia, inevitable abortion, or prematurely ruptured membrane," it "is not clear that [the Act's] 'medical emergency' exception would be defined as broadly as the exception in Casey." App. v.I:331. Inexplicably, despite noting this critical difference (and thereby implicitly acknowledging that the Act might put some women at very serious medical risk), the district court proceeded to hold six pages later: "Because that definition is consistent with the medical exception language in Casey and several other abortion laws that have been found constitutional, the court finds that the medical exception does not cause the Act to fail the undue burden test." App. v.I:337.

For all of these reasons, like the telemedicine abortion ban recently struck down by this Court in PPH I, the Act "places an undue burden on a woman's right to terminate her pregnancy." 865 N.W.2d at 269. Here too,

there is no evidence that the Act would actually advance any valid state interest and 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.

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

The Act also 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 health care, including procedures with far greater risks and those for which patients express similar or higher rates of uncertainty before proceeding. Iowa Const. art. I, §§ 1, 6. Indeed, in PPH I, this 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.'" 865 N.W.2d at 269 (quoting Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 790 (7th Cir. 2013)); see generally Cass R. Sunstein, Neutrality in Constitutional Law (with Special Reference to Pornography, Abortion, and

Surrogacy) 92 Colum. L. Rev. 1, 29–44 (1992) (arguing that abortion restrictions violate women's right to equal protection).

The district court distinguished PPH I on the basis that "[t]here was little evidence presented at trial in the present case regarding consent and waiting periods for other procedures," App. v.I:340. That is incorrect. Petitioners' experts testified that same-day procedures are routine in gynecology, Part I.B.2, above, and Respondents failed to identify *any* other medical procedure for which the state mandates a waiting period, let alone a time-sensitive, hard-to-access procedure such as abortion.

As set forth in Part II.B.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, 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 only for a medical procedure that is only available to women. 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; N.M. Right to Choose/NARAL 975 P.2d at 854 (applying heightened scrutiny to abortion restriction because "[s]ince time immemorial, women's biology and ability to bear children have been used as a basis for discrimination against them"); 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").

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 (noting in finding mandatory delay law violates state constitution's right to due process that the law "insults the intelligence and decision-making capabilities of a woman"); 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 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 (in equal protection context, 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 this

Court's strong protection of patient autonomy, see Part II.B.1, above, or with its proud history of advancing the principle of equality.

Although the district court recognized that women may perceive these laws as insulting and intrusive, it ignored this relevant case law, relying instead on a statement by the late Justice Scalia, in a case about anti-abortion protesters, for its conclusion that the Act did not discriminate on the basis of sex. App. v.I:340 (citing Bray v. Alexandria Women's Health Clinic, 506 U.S. 263, 270–271 (1993)). But Bray said only that people can protest against abortion for reasons other than "hatred of, or condescension toward" women. Bray, 506 U.S. at 270–271; Bray said nothing about the message a *legislature* sends when it singles out abortion and forces all women, regardless of their individual circumstances, to turn back from the abortion clinic after their ultrasound, go back home, and wait at least three days before returning for the procedure no matter how firm they are in their decision.

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. at 897. (internal quotation marks omitted and emphasis added).

While acknowledging that intermediate scrutiny might be the proper standard for Petitioners' Equal Protection claim, the district court did not actually apply that standard before denying Petitioners' claim. Certainly, it did not "drill down" into Respondents' evidence (nor, again, did Respondents actually *present* any evidence). Instead, the district court simply found that it was reasonable to *force all* women to delay their procedure simply because "some women will decide not to follow through with an abortion following an informed consent appointment," App. v.I:339, even though the evidence was that they would decide this regardless of whether the *state* mandates delay. For the same reasons stated above, Part II.B.2, the evidence in this case demonstrates that Respondents' 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 II.B.2, 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. In fact, despite its ruling, the district court seemed to recognize that the Act was extremely over-inclusive. App. v.I:332–333, 338 (agreeing that "there is no question that the Iowa legislature could have written the Act to be less restrictive," and listing several examples). Because the Act applies to all patients indiscriminately, without justification, and does so in a way that shames women and severely burdens access to constitutionally-protected medical care, the Act fails intermediate scrutiny and therefore violations patients' equal protection rights. See Varnum, 763 N.W.2d at 901 ("A law so simultaneously over-inclusive and under-inclusive is not substantially related to the government's objective.").[14]

[14] Even the more deferential rational basis test requires "meaningful review" of whether the *facts* in the case support the state's asserted justification. Varnum, 763 N.W.2d at 879. Here, the facts do not support the Act; the

## CONCLUSION

For the reasons set forth above, Petitioners respectfully request that the Court permanently enjoin the Act's requirement that patients wait 72 hours or longer after having an ultrasound and other screening before having an abortion.

## STATEMENT ON ORAL ARGUMENT

Petitioners request oral argument.

Respectfully submitted,

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undisputed record shows that women already have, and take, the time they need to make the right decision for themselves, and have no need for a paternalistic, state-imposed blanket waiting period before carrying out that decision.

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***Admitted *pro hac vice* in the Iowa District Court case; Admitted *pro hac vice* in the Iowa Supreme Court case**

## COST CERTIFICATE

I hereby certify that the cost of printing this application was $0.00 and that that amount has been paid in full by the undersigned.

## CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(*g*)(1) or (2) because:

[ x ] this brief contains 13,926 words, excluding the parts of the brief exempted by Iowa R. App. P. 6.903(1)(*g*)(1) or

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/s/ Rita Bettis
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