United States Court of Appeals

for the

Eighth Circuit

Case No. 16-2234

PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself and its patients, doing business as Planned Parenthood Great Plains; STEPHANIE HO, MD, on behalf of herself and her patients,

Plaintiffs-Appellees,

– v. –

LARRY JEGLEY, Prosecuting Attorney for Pulaski County, in his official capacity, his agents and successors; MATT DURRETT, Prosecuting Attorney for Washington County, in his official capacity, his agents and successors,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS, CASE NO. 4:15-CV-00784-KGB THE HONORABLE KRISTINE G. BAKER

MOTION FOR LEAVE TO FILE *AMICUS* BRIEF

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Pursuant to Federal Rules of Appellate Procedure 27 and 29(b), the American College of Obstetricians and Gynecologists ("ACOG" or the "College") and the American Public Health Association ("APHA") move for leave to file a brief as *amici curiae*. The proposed *amici curiae* brief is being filed as an exhibit to this motion, as required by Federal Rule of Appellate Procedure 29(b) and (e). The motion and the accompanying proposed brief are being filed timely as required by Federal Rule of Appellate Procedure 29(e). ACOG and APHA sought consent from all parties for the filing of their brief pursuant to Fed. R. App. P. 29(a). Counsel for all parties have consented to the filing of this brief. [1]

Interest of *Amici Curiae*

ACOG is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of healthcare of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members.

[1] ACOG and APHA understand this Court prefers the filing of a motion even when all parties have consented to the filing of an *amicus* brief, and accordingly file this motion.

Sharing more than 57,000 members, including 294 in Arkansas, the College and the Congress are the leading professional associations of physicians who specialize in the healthcare of women.

APHA, an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research. APHA has over 20,000 members, 76 of whom reside in Arkansas and also has maintained a connection to the public health community in Arkansas through its affiliate, the Arkansas Public Health Association, which has provided nearly 69 years of public health service. With a membership of about 456, the Arkansas Public Health Association serves Arkansas residents by supporting a scientifically based public health approach and advocating for important public health issues impacting Arkansans.

ACOG and APHA seek leave to appear as *amici curiae* here because the law being challenged in this case restricts women's ability to obtain safe, legal, and quality abortion services in Arkansas. ACOG and APHA are leading medical and public health professional organizations that play a prominent role in advancing reproductive healthcare in the United States. They have been granted leave to appear as *amicus curiae* in various courts throughout the country on matters relating to reproductive health, including the Eighth Circuit and the United States

Supreme Court, and the brief they seek leave to file provides additional insight about the critical reproductive health topics at issue in this case. Thus, ACOG and APHA desire to bring their views before the Court, and to assist the Court as it addresses the complex and important issues raised by the parties in this matter.

Reasons Why the Brief of *Amici Curiae* Is Desirable and Why the Matters Asserted Are Relevant

It is critical to the public health interests of the United States that all women have meaningful access to reproductive health services, including abortion. Act 557, Ark. Code Ann. § 1501 *et seq.* (the "Act"), specifically the contracted physician requirement of the Act, is both a medically unnecessary and a harmful restriction on the provision of abortion. The requirement that any physician who administers medication abortions must contract with a physician with active admitting privileges at a hospital does nothing to enhance the quality or safety of abortion care, and in fact creates a grave risk to public health.

Legal abortion, including medication abortion, is extremely safe, and the contracted physician requirement will not make it safer. Instead, the contracted physician requirement serves only to impede and diminish access to reproductive care without improving that care for the few women who would be able to obtain it. Its burdens far outweigh the nonexistent health benefits relied upon by the State

and this Court should affirm the preliminary injunction against the contracted physician requirement.

APHA and ACOG respectfully urge the Court to accept its *amici curiae* brief in order to benefit from the presentation of both sides of this important issue.

Conclusion

For the foregoing reasons, ACOG and APHA request leave to appear as *amici curiae* and to file the proposed brief that accompanies this motion.

November 9, 2016

Respectfully submitted,

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CIRCUIT RULE 28A(H) CERTIFICATION

I hereby certify the motion has been scanned for viruses and that it is virus-free.

November 9, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 9, 2016, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

November 9, 2016

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BRIEF OF *AMICI CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION AND AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF APPELLEES

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CORPORATE DISCLOSURE STATEMENT PURSUANT TO FRAP 26.1

Amicus curiae, the American College of Obstetricians and Gynecologists is a non-profit organization, with no parent corporations or publicly traded stock.

Amicus curiae, the American Public Health Association is a non-profit organization, with no parent corporations or publicly traded stock.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae, the American College of Obstetricians and Gynecologists ("ACOG" or the "College") and the American Public Health Association ("APHA") submit this brief in support of Appellees Planned Parenthood of Arkansas & Eastern Oklahoma d/b/a Planned Parenthood Great Plaines and Stephanie Ho ("Appellees").[1]

ACOG is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of healthcare of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members.

[1] Pursuant to Federal Rule of Appellate Practice 29, undersigned counsel for *amici curiae* certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than *amici curiae*, its members, and its counsel—contributed money intended to fund the preparation or submission of this brief.

Sharing more than 57,000 members, including 294 in Arkansas, the College and the Congress are the leading professional associations of physicians who specialize in the healthcare of women.

APHA is an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research. APHA is the only organization that combines a 140-plus-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

APHA has over 20,000 members, 76 of whom reside in Arkansas and also has maintained a connection to the public health community in Arkansas through its affiliate, the Arkansas Public Health Association, which has provided nearly 69 years of public health service. With a membership of about 456, the Arkansas Public Health Association serves Arkansas residents by supporting a scientifically based public health approach and advocating for important public health issues impacting Arkansans.

APHA and ACOG have long recognized that access to the full range of reproductive health services, including abortion, is a fundamental right integral both to the health and well-being of individual women and to the broader public health. APHA and ACOG oppose restrictions that deny, delay, and impede access

to abortion services, increasing women's risk of injury or death, and that coerce women to carry unintended pregnancies to term. APHA and ACOG have previously been granted leave to appear as *amicus curiae* in various courts throughout the country on matters relating to reproductive health, including in the Eighth Circuit and in the United States Supreme Court.

SUMMARY OF THE ARGUMENT

It is critical to the public health interests of the United States that all women have meaningful access to reproductive health services, including abortion. When state legislatures enact laws restricting women's access to abortion without any valid medical justification, they jeopardize women's health. Act 577, Ark. Code Ann. § 20-16-1501 *et seq.* (2016) (the "Act") is one such law, and the contracted physician requirement of the Act is medically unnecessary and a harmful restriction on the provision of abortion. The requirement that any physician who administers medication abortions must contract with a physician with active admitting privileges at a hospital does nothing to enhance the quality or safety of abortion care, and in fact creates a grave risk to public health.

Legal abortion, including medication abortion, is extremely safe, and the contracted physician requirement will not make it safer. Instead, the contracted physician requirement serves only to impede and diminish access to reproductive care without improving that care for the few women who would be able to obtain

it. The Act jeopardizes women's health and the collective public health of Arkansas by imposing requirements that would force two out of the three legal abortion providers to stop providing abortion services, and likely eliminate medication abortion entirely in the state. Given the state's particularly vulnerable population—Arkansas is among the poorest states in the country and is largely rural—by depriving women in Arkansas of safe, local reproductive care, the contracted physician requirement creates a substantial risk that women in Arkansas will seek out illegal abortions, or face the serious mental and physical health risks of being forced, due to circumstance, to carry unwanted pregnancies to term.

For these and the reasons set forth below—and because the contracted physician requirement of the Act imposes substantial and unconstitutional obstacles to the exercise of a constitutional right—*amici* support Appellees and urge the Court to affirm the District Court's decision issuing a preliminary injunction preventing the enforcement of the contracted physician requirement of the Act.

ARGUMENT

I. Access to Reproductive Health Services, Including Abortion, Is Critical to a Fully Functioning Public Health System

The contracted physician requirement jeopardizes the public health in Arkansas by imposing legislative constraints on access to safe and legal abortion without any corresponding medical benefit. Without access to abortion, women of

reproductive age face significantly increased risks to their health, including risks of major complications from childbirth and increased risks of death. Abortion is an essential component of comprehensive reproductive care, and when unnecessary restrictions are placed on access to abortion, women's health—and thus public health—suffers.

Amici ACOG and APHA recognize that protecting and promoting the health of women, and women's ability to make choices about their health and the medical care they receive, is essential to the health of the public overall. *Amici* have long recognized that access to affordable and acceptable reproductive health services, including abortion, is critical to a fully functioning public health system and is a necessary component of women's health care. *Amici* recognize that legislation that restricts access to reproductive care, such as the contracted physician requirement at issue here, disproportionately decreases access to reproductive care among women of color and rural and low-income women.[2] *Amici* support abortion care as an essential component of medical care for women.[3]

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[2] APHA, *Policy Statement No. 20151—Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers* (Nov. 3, 2015), *available at* http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/14/11/04/opposition-to-requirements-for-hospital-admitting-privileges-for-abortion-providers [hereinafter "*APHA Policy Statement No. 20151*"]; ACOG, Comm. on Health Care for Underserved Women, *Opinion No. 613—Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060, 1060, 1063–64 (2014) [hereinafter "*ACOG Committee Opinion No. 613—Increasing Access to*

II. The Contracted Physician Requirement Injures Public Health by Imposing Medically Unnecessary Restrictions on Abortion Care

A. Medication Abortion Is an Extremely Safe Procedure

Legal abortion is extremely safe. It is "one of the most common and safest gynecologic interventions in the United States"[4] and "[m]ajor complications that require hospitalization are rare."[5] More than 90% of U.S. abortion procedures are performed through outpatient clinics.[6] The regimen used by Appellees has been used by Planned Parenthood since 2006, has been recognized by ACOG and others to have improved the safety of medication abortion procedures,[7] and has been

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Abortion"]; ACOG, College Executive Board, *Abortion Policy*, *available at* https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20161104T1513538114.

[3] *Id.*

[4] APHA, *Policy Statement No. 20112—Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Nov. 1, 2011), *available at* https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

[5] ACOG, *FAQ043 Special Procedures—Induced Abortion* 2 (May 2015), *available at* https://www.acog.org/-/media/For-Patients/faq043.pdf?dmc=1&ts=20161103T1611342742.

[6] Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 46 (Table 4) (2011) (showing that, in 2008, 70 percent of abortions were performed at "abortion clinics" and 24 percent were performed at "other clinics").

[7] *See* James Trussell et al., *Reduction in Infection-Related Mortality since Modifications in the Regimen of Medical Abortion*, 89 Contraception 193, 193

approved by the U.S. Food and Drug Administration.[8] Mifepristone, like all medication, carries some risks, but is recognized to be as safe, or safer, than many other drugs used today, including Tylenol and Viagra.[9]

Medication abortion is "an important alternative" to surgical methods.[10] In 2012, the most recent year for which Centers for Disease Control and Prevention ("CDC") surveillance data has been released, medication abortion accounted for nearly 22% of reported abortions in the United States.[11] Approximately 40% of the

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(2014) (finding that Planned Parenthood's evidenced-based medication abortion protocol reduced mortality rates in medication abortions); ACOG, Comm. on Practice Bulls.—Gynecology & the Soc'y of Fam. Plan., *Practice Bulletin No. 143—Medical Management of First Trimester Abortion*, 123 Obstetrics & Gynecology 676, 677 (2014) ("Additional 'evidence-based' regimens have been developed to improve [medication] abortion in terms of expense, safety, speed, and adverse effects.") [hereinafter "*ACOG Practice Bulletin No. 143—Medical Management of First Trimester Abortion*"].

8 *Mifeprex (Mifepristone) Information*, U.S. Food & Drug Admin., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm (last updated Mar. 30, 2016).

9 *The Woman's Health Protection Act: Hearing on S. 1696 Before the Senate Comm. on the Judiciary*, 113th Cong. 3 (2014) (testimony of Hal C. Lawrence, Executive Vice President and CEO, American Congress of Obstetricians and Gynecologists), *available at http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/20140715S1696Testimony.pdf* [hereinafter "*Lawrence Testimony*"].

10 Thoai D. Ngo et al., *Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: A Systematic Review*, 89 Bull. World Health Org. 360, 360 (2011).

11 Karen Pazol, Andreea A. Creanga & Denise J. Jamieson, Ctrs. for Disease Control & Prevention, *Abortion Surveillance – United States, 2012*, Morbidity

first-trimester abortions at Planned Parenthood health centers in 2012 were performed using a medication abortion procedure.[12]

Medication abortion is preferable to surgical abortion in certain situations. Up to seven weeks, medication abortion is usually more effective than the surgical method used for early abortion procedures.[13] Many women also prefer medication abortion to avoid a surgical procedure, and believe medication abortion to be more natural than a surgical abortion.[14] For some women, such as those who are extremely obese, have large uterine fibroids, or a narrow cervix, medication abortions are safer than surgical abortions.[15]

Similar to the high effectiveness and safety statistics associated with surgical abortion, "complications with [medication] abortion are relatively infrequent."[16]

& Mortality Wkly. Rep., Nov. 27, 2015, at 28 (Table 11). Medication abortion accounted for almost 17 percent of the reported abortions in Arkansas during 2012. *Id.*

[12] Trussell et al., *supra* note 7, at 193.

[13] Marge Berer, *Medical Abortion: Issues of Choice and Acceptability*, 13 Reprod. Health Matters 25, 27 (2007) (stating that the early aspiration procedure might "be incomplete because the gestational sac can be missed").

[14] *Id.* at 26–27.

[15] *Lawrence Testimony*, *supra* note 9, at 3.

[16] Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 166 (2013); *see also* Luu Doan Ireland, Mary Gatter & Angela Y. Chen, *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126

According to a published review, less than one percent of the medication abortions performed at Planned Parenthood health centers in 2009 and 2010 resulted in significant adverse events or outcomes.[17] Only 0.10% of cases resulted in emergency department treatment, 0.06% resulted in hospital admission, and 0.05% resulted in a blood transfusion.[18] In fact, ongoing intrauterine pregnancy, which "is not a complication that is related to the safety of [medication] abortion the same way serious infection or blood transfusion is," was the most commonly reported significant adverse effect or outcome.[19]

Deaths from legal abortion are extremely rare. Less than one death occurred per 100,000 legally induced abortion procedures such as medication abortion,

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Obstetrics & Gynecology 22, 22 (2015) ("Medication abortion and surgical abortion before 64 days of gestation are both highly effective with low complication rates.").

[17] Cleland et al., *supra* note 16, at 166 (defining "significant adverse events" as "hospital admission, blood transfusion, emergency department treatment, intravenous antibiotics administration, infection, and death" and "significant outcomes" as "ongoing pregnancy and ectopic pregnancy diagnosed after [medication] abortion treatment was initiated").

[18] *Id.* at 169 (Table 2) (the review also found that only 0.02 percent of medication abortions at Planned Parenthood healthcare centers in 2009 and 2010 resulted in the administration of intravenous antibiotics and 0.016 percent resulted in infection).

[19] *Id.* at 169 (noting that ongoing intrauterine pregnancy "is of clinical significance only if it is unrecognized through follow-up and the patient does not have a surgical abortion").

performed in the United States between 1998 and 2010.[20] By comparison, the CDC reported between 12.0 and 17.8 pregnancy-related deaths per 100,000 live births per year over the same time period.[21] In short, medication abortion is an exceptionally safe medical procedure.

B. The Contracted Physician Requirement Offers No Medical Benefit to Women

The contracted physician requirement—which requires providers of medication abortion to contract with a physician with admitting privileges at a hospital—is not grounded in any evidence-based practice, provides no public health benefit, and instead serves to restrict the provision of abortion care in Arkansas.[22]

First, the universe of women with serious complications arising from legal abortion requiring hospitalization or surgical care is ***less than one-quarter of one percent*** of the patient population.[23] In the rare event of a complication, women

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[20] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 258 (2015).

[21] *Pregnancy Mortality Surveillance System*, Ctrs. for Disease Control & Prevention, http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (last updated Jan. 21, 2016).

[22] *APHA Policy Statement No. 20151*, *supra* note 2; *ACOG Committee Opinion No. 613—Increasing Access to Abortion*, *supra* note 2, at 1061–62.

[23] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

typically seek medical care at their local hospitals, which are competent to treat patients suffering adverse effects from medication abortion, which are similar to miscarriages.[24] Seeking care from a local hospital where they cannot be turned away or denied emergency care in the event of a complication from any outpatient procedure is consistent with modern medical practice.[25] For those women with continuing pregnancies following medication abortion—reported in less than 1% of women following the evidence-based regimen—a repeat dose of misoprostol or referral to a clinician trained in surgical abortion on a non-urgent basis, as followed by Appellees, is consistent with ACOG's recommendations.[26] Neither of these

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[24] *See id.* at 175–76; *see also* Cleland et al., *supra* note 16, at 166; *Lawrence Testimony*, *supra* note 9, at 5 ("In the rare instance when a woman experiences a complication after an abortion and needs hospital care, emergency room physicians or, if necessary, the hospital's on-call specialist, are trained to evaluate such situations the same way they are trained to deal with complications arising from any other medical procedure."); Letter from Ralph Hale, Exec. V.P. ACOG, to Jane Henney, Comm'r, U.S. Food & Drug Admin. (Jul. 24, 2000), *available at* http://www.aaplog.org/wp-content/uploads/2002/05/ACOGAnalysisMifepristone7-27-00.pdf (enclosing ACOG, *Analysis of the Possible FDA Mifepristone Restrictions*, 5 (July 27, 2000) explaining that admitting privileges for clinicians providing medication abortion are unnecessary because "[w]omen experiencing miscarriages and spontaneous abortions frequently require the same services and care.").

[25] *APHA Policy Statement No. 20151*, *supra* note 2.

[26] *See ACOG Practice Bulletin No. 143—Medical Management of First Trimester Abortion*, *supra* note 7, at 680; *see also Planned Parenthood Ark. & E. Okla v. Jegley*, No. 4:15-cv-00784-KGB, slip op. at 9–10 (E.D. Ark. Mar. 14, 2016), ECF No. 60. Continuing pregnancies generally do not require urgent surgical

options requires a contracted physician. Moreover, the contracted physician requirement ignores the existing realities of abortion care: the very few patients requiring medical attention following an abortion may be hundreds of miles away from the facility at which they obtained abortion services, and likely the contracted physician's hospital, by the time they experience any complications.[27]

The transfer of care from an outpatient provider to an emergency room physician or surgical abortion provider when necessary is also consistent with the developments dividing ambulatory and hospital care, and is standard medical practice.[28] Not only is it accepted, but it is also expected that anyone suffering complications from a medical procedure will go to their nearest hospital for treatment.[29] In contemporary practice, continuity of care is achieved not by a single doctor following the patient to the hospital, but through communication and collaboration among specialized health care providers, wherever they are.[30]

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completion. *See ACOG Practice Bulletin No. 143—Medical Management of First Trimester Abortion*, *supra* note 7, at 680–81.

[27] *APHA Policy Statement No. 20151*, *supra* note 2.

[28] *See Lawrence Testimony*, *supra* note 9, at 5.

[29] *APHA Policy Statement No. 20151*, *supra* note 2 ("Seeking care from an unaffiliated hospital does not pose a real harm to patients, as they can visit the closest hospital and, under [federal law], cannot be turned away or denied care.").

[30] *See Lawrence Testimony*, *supra* note 9, at 5; *see also* ACOG, Committee on Health Care for Underserved Women, *Opinion No. 657—The Obstetric and*

Appellees meet this standard of care by ensuring that patients with complications return to the clinic, are referred to a local hospital, or referred to a clinic where they may obtain a surgical abortion.[31] In each case, Appellees are able to communicate necessary health information to the treating physician. Requiring a woman's abortion provider to contract with a third-party physician with privileges at a nearby hospital does not guarantee that the contracted physician will be available if complications arise later; have any familiarity with the patient's history; or improve the care the patient is likely to receive from the emergency staff and specialists who will care for her at the hospital.[32] In a nutshell, there is simply no

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Gynecologic Hospitalist, (Feb. 2016), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co657.pdf?dmc=1&ts=20161107T1513487159; Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* 8–9 (Mar. 2001) (noting that "access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits" and describing guidelines for ensuring patients receive care whenever they need it).

[31] *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB, slip op. at 8–10 (E.D. Ark. Mar. 14, 2016), ECF No. 60.

[32] *See Lawrence Testimony*, *supra* note 9, at 5 (explaining that a woman experiencing complications will see emergency room physicians, or on-call specialists, and hospitals "increasingly rely on 'hospitalists' that provide care only in a hospital setting").

evidence that the contracted physician requirement improves women's health or safety.[33]

Second, as demonstrated by the evidence before the District Court[34] as well as experiences elsewhere, the contracted physician requirement, like other restrictions targeting abortion providers, is likely to result in a loss of critical abortion care in Arkansas. Such restrictions have tangible and negative health consequences for patients seeking abortion care, as further described below.

III. The Act Jeopardizes the Public Health in Arkansas by Limiting Abortion Care in the State to a Single Facility in Little Rock

The contracted physician requirement will force two of the three remaining clinics in Arkansas that provide abortion services to stop providing these services.[35] Only one provider of abortions, which is based in Little Rock, could continue providing legal abortions in Arkansas, and will likely only be able to provide surgical abortions.[36] By forcing reproductive health care facilities to stop

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[33] *See ACOG Committee Opinion No. 613—Increasing Access to Abortion*, *supra* note 2, at 1062 (stating that similar "TRAP laws" are "medically unnecessary requirements designed to reduce access to abortion").

[34] *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB, slip op. at 68–69 (E.D. Ark. Mar. 14, 2016), ECF No. 60.

[35] Suzanna de Baca Decl. at 4–5, ¶¶ 12–14, *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB (E.D. Ark.), ECF No. 2.

[36] *Id*. at 5, ¶ 13; *see also Planned Parenthood Ark. & E. Okla v. Jegley*, No. 4:15-cv-00784-KGB, slip op. at 68 (E.D. Ark. Mar. 14, 2016), ECF No. 60 (referencing the allegation that the contracted physician requirement would

providing abortion services, the Act will cause women to wait longer and travel farther to access abortion services in Arkansas. The contracted physician requirement will have a particularly devastating impact on the health and safety of low-income women, who already face considerable barriers to reproductive health care.

A. Arkansas Is Particularly Vulnerable to Public Health Risks, Including Restrictions on Reproductive Care

The risks to public health caused by restricted access to medication abortion services are particularly acute in Arkansas. Arkansas has one of the highest poverty rates in the United States; nineteen percent, nearly one of every five, Arkansans live below the poverty line.[37] Arkansas's population is not just poor, but also largely rural,[38] making access to abortion care especially challenging.[39]

"mak[e] abortions available only in Little Rock, and mak[e] only surgical abortions available").

[37] *See* Talk Poverty, *Overall Poverty, 2016*, Ctr. for Am. Progress, https://talkpoverty.org/indicator/listing/poverty/2016 (last visited Nov. 3, 2016). Only three states—Mississippi, New Mexico, and Louisiana—have higher poverty rates. *Id.*

[38] *See* Iowa Community Indicators Program, *Urban Percentage of the Population for States, Historical*, Iowa State Univ., http://www.icip.iastate.edu/tables/population/urban-pct-states (last visited Nov. 3, 2016) (showing that only 56.2% of the Arkansas population lived in an urban area, among the lowest urban population percentages in the nation, according to 2010 U.S. Census Bureau data).

[39] *ACOG Committee Opinion No. 613—Increasing Access to Abortion*, *supra* note 2, at 1063 (listing rural and poor women among the vulnerable populations who

Women in Arkansas are particularly vulnerable to the ratcheting up of abortion restrictions because the state already severely burdens abortion care through existing regulations while providing inadequate support for family planning and maternal health.

1. The Public Health Risks Caused by Restricted Access to Abortion Care Are Greater for Low-Income and Rural Populations

The median household income in Arkansas was $41,264 between 2010 and 2014.[40] By comparison, Maryland had the highest median household income, at $74,149 per household.[41] More than one in four children in Arkansas, and nearly one in five of Arkansas's citizens overall, live below the poverty line.[42]

Low-income women in Arkansas currently face significant financial barriers to accessing reproductive care, which will only be exacerbated if the contracted

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"can face additional restrictions on access to abortion as well as disproportionate effects from other barriers"); *see also* ACOG, Comm. on Health Care for Underserved Women, *Opinion No. 586—Health Disparities in Rural Women*, 123 Obstetrics & Gynecology 384, 385 (2014) (stating that "[l]ocal availability of abortion services . . . is a concern" for rural women).

[40] *Quick Facts: Arkansas*, U.S. Census Bureau, http://www.census.gov/quickfacts/table/PST045215/05 (last visited Nov. 3, 2016).

[41] *Quick Facts: Maryland*, U.S. Census Bureau, http://www.census.gov/quickfacts/table/PST045215/24 (last visited Nov. 3, 2016).

[42] Talk Poverty, *Arkansas, 2016*, Ctr. for Am. Progress, https://talkpoverty.org/state-year-report/arkansas-2016-report (last visited Nov. 3, 2016).

physician requirement is permitted to come in to effect. The majority of women seeking abortion care already have at least one child.[43] The federal poverty line for a single person with a child in 2016 is $16,020, which equates to a monthly income of $1,335.[44] The current fair market rent for a one-bedroom apartment in or near Little Rock, Arkansas is $673 per month.[45] The numbers suggest that a single woman with one child living at the poverty line and paying fair market rent for a one-bedroom apartment in Little Rock would have a mere $662 of disposable income per month after rent to cover transportation expenses, clothing, food, and other necessities for herself and her child. In Arkansas, over 40% of single-parent families live below the poverty line and do not earn even this level of disposable income.[46] Although the cost of an abortion has not significantly risen in recent

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[43] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358, 1363 (2011).

[44] *See U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*, U.S. Dep't of Health & Human Servs. (Jan. 25, 2016), https://aspe.hhs.gov/poverty-guidelines.

[45] FY 2017 Fair Market Rent Documentation System, *FY 2017 Little Rock-North Little Rock-Conway, AR HUD Metro FMR Area FMRs for All Bedroom Sizes*, U.S. Dep't of Hous. & Urban Dev., https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2017_code/2017summary.odn?cbsasub=METRO30780M30780&year=2017&fmrtype=$fmrtype$ (last visited Nov. 3, 2016).

[46] *Arkansas*, Spotlight on Poverty & Opportunity, http://spotlightonpoverty.org/states/arkansas/ (last visited Nov. 3, 2016),

years,[47] it still costs hundreds of dollars.[48] With only rare exceptions, neither federal nor state Medicaid will cover the cost of abortion care for women in Arkansas.[49]

Further, due to a combination of factors, including lack of access to medical services and difficulty accessing and affording contraceptives,[50] low-income women have more unintended pregnancies and higher abortion rates than women

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47 Jones & Kooistra, *supra* note 6, at 49 ("[A]fter adjustment for inflation, the average amount that women paid for a first-trimester surgical abortion increased by only $11 between 2006 and 2009."); *see also* Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States: 2001*, 35 Persp. on Sexual & Reprod. Health 16, 16 (2003).

48 Christine Dehlendorf, Lisa H. Harris & Tracy A. Weitz, *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1772, 1776 (2013); Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 334 (2006).

49 *See* Stanley K. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 3 (2009), *available at* https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review (explaining that federal and state Medicaid funding is available to Arkansas women only in cases of rape, incest, or life-endangering physical condition).

50 *See, e.g.*, Dehlendorf, Harris & Weitz, *supra* note 48, at 1772; Guttmacher Inst., *Contraceptive Use in the United States* 1 (2016), *available at* https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states ("Among women who are at risk of unintended pregnancy, 92% of those with incomes of 300% or more of the federal poverty level are currently using contraceptives, as are 89% of those living at 0–149% of the poverty line."); Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. Health Care for Poor & Underserved 415, 415 (2011).

with higher incomes.[51] A disproportionately high percentage of women who seek abortions have poverty-level incomes. In 2014, approximately 49% of American women who had abortions had incomes below the federal poverty level, and an additional 26% of women who had abortions qualified as low-income, which means their income was 100–199% of the federal poverty level.[52]

The combination of low incomes, unintended pregnancies and higher abortion rates is felt more keenly in Arkansas, where women are not only, on average, poorer than women nationally, but the number of unintended pregnancies is higher than the national average.[53] Arkansas women who make the decision to

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[51] "The rate of unintended pregnancy among poor women . . . was 112 per 1,000 aged 15-44 in 2011, more than five times the rate among women at the highest income level (20 per 1,000)." Guttmacher Inst., *Unintended Pregnancy in the United States* 2 (2016), *available at* https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. The rate of abortion was also significantly higher among low-income women. *See* Dehlendorf, Harris & Weitz, *supra* note 48, at 1772 ("In 2008 . . . women with incomes less than 100% of the federal poverty level . . . hav[e] abortion rates of 52 abortions per 1000 reproductive-age women, compared with a rate of 9 per 1000 among those with incomes greater than 200% [of the federal poverty level].").

[52] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, 1 (2016).

[53] In 2010, 55% of pregnancies in Arkansas were unintended, as compared to 45% of pregnancies nationwide. Guttmacher Inst., *State Facts About Unintended Pregnancy: Arkansas* 1 (2016), *available at* https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-arkansas.

terminate a pregnancy should be able to access a full range of safe and legal abortion care in their own state.

2. The Public Health Risks Caused by Restricted Access to Abortion Care Are Greater in Arkansas Because Arkansas' Existing Restrictions on Abortion Care and Lack of Family Planning Support

By restricting access to abortion in other legislation, Arkansas has already damaged the public health and the health of the individual women and children who live in the state. Even before the Act was passed, Arkansas placed 49th in the country in terms of women's health, far behind less restrictive states like Vermont or Massachusetts, which place relatively few obstacles to abortion access and are ranked in the top two overall in women's health.[54] Arkansas requires women seeking to terminate a pregnancy to participate in state-directed counseling that includes information designed to discourage them from having an abortion and to wait at least 48 hours after that counseling before proceeding with an abortion.[55]

The public health impact of Arkansas's legislative obstacles to abortion access is compounded by the state's lack of support for family planning services or birth control and the high rate of unintended pregnancy in Arkansas. Publicly supported family planning centers in the state met only 29% of Arkansas women's

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[54] Making the Grade on Women's Health: A National State by State Report Card, *Key Findings*, Nat'l Women's L. Ctr., http://hrc.nwlc.org/key-findings (last visited Nov. 3, 2016).

[55] *See* Ark. Code Ann. § 20-16-1703 (2015).

need for contraceptive services and supplies.[56] In 2010, 55% of all pregnancies in Arkansas were unintended.[57] That same year, 67% of unintended pregnancies in the state resulted in births and 18% in abortions.[58] By underfunding publicly supported family planning services, the Arkansas legislature has created an even greater likelihood of high rates of unintended pregnancy and a correspondingly greater need for comprehensive reproductive care, including abortion care.

B. By Limiting Abortion Care to Little Rock, the Contracted Physician Requirement Jeopardizes Public Health in Arkansas

If the contracted physician requirement takes effect, Arkansas women who previously had access to an abortion facility in Fayetteville will be forced to undertake arduous and expensive travel in order to obtain an abortion—if they can do so at all. Such women are more likely to carry their pregnancies to term—a risk to their own health. Additionally, some women may turn to unsafe, illegal methods to terminate their pregnancies in the absence of more legal abortion services.

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[56] Guttmacher Inst., *State Facts About Unintended Pregnancy: Arkansas*, *supra* note 53, at 2

[57] *Id.*

[58] *Id.*

1. The Act Will Likely Force Women to Wait Longer and Travel Farther to Obtain Abortion Services

The reduction of abortion providers in Arkansas to a sole clinic in Little Rock would force women to wait longer and travel farther to obtain in-state abortion services. If the contracted physician provision takes effect, women in Arkansas will find it even more difficult to secure an appointment at the state's one remaining facility, traverse hundreds of miles to make multiple trips to that facility to comply with the state's mandatory waiting period, and raise enough money to fund all of the costs of travel—including transportation, overnight lodging, child care, and other attendant costs[59]—on top of the cost of the abortion itself. Some women may be prevented from obtaining an abortion at all, be forced to carry an unwanted pregnancy to term, and experience the physical and mental burdens of pregnancy and childbirth—and the overall detrimental impact on public health exacerbates medical inequality.[60]

The effects of the contracted physician provision are likely to be particularly acute for low-income women in places like western Arkansas, which is home to

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[59] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

[60] Dehlendorf, Harris & Weitz, *supra* note 48, at 1775-77.

two of Arkansas's largest cities, Fayetteville and Fort Smith.[61] The U.S. Census Bureau reported that over a quarter (25.2% and 25.9% respectively) of residents in both Fayetteville and Fort Smith have incomes below the federal poverty line.[62] For patients whose annual family income is at or below the poverty level—the out-of-pocket cost of the abortion procedure alone is substantial, and the additional costs, challenges, and requirements may be prohibitive. Even researching and planning for an abortion procedure can be a challenge for those who lack Internet access—which cannot be assumed, particularly for low-income women in Arkansas, which is ranked second-to-last in the United States in terms of Internet connectivity.[63]

Currently, Fayetteville is the only Arkansas city other than Little Rock to offer abortion care. If the contracted physician requirement is permitted to become operative, that facility will no longer be able to provide abortion services. Women in Fayetteville would have to make the 380-mile round-trip to Little Rock to access

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61 *Arkansas - Largest Cities*, GeoNames, *http*://www.geonames.org/US/AR/largest-cities-in-arkansas.html (last visited Nov. 3, 2016).

62 *American Fact Finder*, U.S. Census Bureau, http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml (last visited Nov. 3, 2016) (search Fayetteville and Fort Smith before navigating to the "Poverty" tab on each webpage).

63 Ria Misra, *Which State Has the Worst Internet Access in the Nation?*, Gizmodo (Nov. 14, 2014, 11:35AM), http://io9.gizmodo.com/which-state-has-the-best-internet-access-in-the-nation-1658816647.

an abortion provider, and will no longer be able to obtain a medication abortion at all.[64] Likely, they would need to make this trip twice, once for the required state-directed counseling, and then, 48 hours later, another for the procedure.[65] For those women that do have access to a vehicle, the fuel alone for the round-trip 760 mile ride costs roughly $69.[66] That may be a daunting and time-consuming drive even for those with cars—but in Fayetteville, access to a car cannot be assumed. Over 10,000 residents in Fayetteville live in households that do not have access to a vehicle.[67]

The bus route from Fayetteville to Little Rock is long, slow, expensive, and infrequent. It runs once daily, departing from Fayetteville at roughly 2:00 a.m. every day and leaving Little Rock at 5:45 a.m. every day. As a result, a woman taking the bus from Fayetteville to Little Rock would be forced to leave at 2:00 a.m. on day one, arriving in Little Rock in the early morning, undergo state-mandated counseling, find somewhere to sleep in Little Rock, and then leave at

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[64] *Planned Parenthood Ark. & E. Okla v. Jegley*, No. 4:15-cv-00784-KGB, slip op. at 22 (E.D. Ark. Mar. 14, 2016), ECF No. 60.

[65] *See* Ark. Code Ann. § 20-16-1703 (2015). This does not include the additional follow-up visit which the Act requires to be scheduled. *See* Ark. Code Ann. § 20-16-1504(e)(1) (2016).

[66] Assuming a vehicle with 25 mpg, and a fuel price of $2.27.

[67] Alan Berube et al., *Socioeconomic Differences in Household Automobile Ownership Rates: Implications for Evacuation Policy* (June 2006), http://socrates.berkeley.edu/~raphael/BerubeDeakenRaphael.pdf.

5:45 a.m. on day two to return to Fayetteville; only to repeat this journey after the 48-hour time has elapsed. The bus ride from Fayetteville to the only remaining abortion facility in Little Rock by bus would take roughly four to five hours, and cost from nearly $52 to $122 round-trip,[68] followed by a 10-mile walk or taxi ride to the clinic. Travel from other, rural areas, will pose similar, if not more onerous, challenges.[69]

By limiting abortion care to just a single clinic in the entire state, Arkansas's contracted physician requirement would leave women across the state with formidable challenges to overcome to get basic, safe, reproductive care. For those making near or below the federal poverty level, the costs and time required to travel hundreds of miles multiple times to the sole remaining facility may well be prohibitive.

2. The Act May Result in More Women Carrying Unwanted Pregnancies to Term and Risking Their Own Health

Studies have demonstrated that when access to abortion care is limited, women are more likely to carry an unwanted pregnancy to term, which poses

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[68] Greyhound, https://www.greyhound.com/ (last visited Nov. 3, 2016) (search for roundtrip fares between Fayetteville and Little Rock).

[69] The bus route from Fort Smith to Little Rock is similarly expensive, long, slow, and infrequent. *See* Greyhound, https://www.greyhound.com/ (last visited Nov. 3, 2016) (search for roundtrip fares between Fort Smith and Little Rock).

greater risk to the woman's health than legal abortion.[70] If women in Arkansas are forced to travel farther to obtain an abortion, they are less likely to obtain one.[71] All pregnancies involve risks of both physical and psychological complications.[72] Some of these risks can be fatal, while others, such as depression, persist even after childbirth.[73] That risk is particularly high for minorities.[74] The risks associated with unwanted pregnancies are particularly troubling. For women, the risk of

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[70] Paul M. Fine Decl., at 20–21, ¶ 55, *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB (E.D. Ark.), ECF No. 2.

[71] *See* James D. Shelton, Edward A. Brann & Kenneth F. Schultz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260, 260 (1976).

[72] *See generally* World Health Org., Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors, (2000) (providing a manual for health care providers that describes the various risks associated with pregnancy), *available at* http://apps.who.int/iris/bitstream/10665/43972/1/9241545879_eng.pdf.

[73] *See Pregnancy Complications*, Ctrs. for Disease Control & Prevention, http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm (last updated June 17, 2016).

[74] *See* Robert W. Brown, R. Todd Jewell & Jeffrey J. Rous, *Provider Availability, Race, and Abortion Demand*, 67 S. Econ. J. 656, 667 (2001) (finding that increasing the distance to the closest abortion provider by 10% would reduce the probability of abortion by 5.01% and 2.70% for Hispanics and African Americans, respectively, while only reducing the probability by 2.32% for whites). Racial minorities account for approximately half of the abortions reported in Arkansas. *See Induced Abortions Data – Act 353, 2015*, Ark. Dep't of Health, http://www.healthy.arkansas.gov/programsServices/healthStatistics/Documents/abortion/ITOP_Reports_2015.pdf (last visited Nov. 3, 2016) (showing that of the 3,771 abortions performed in Arkansas in 2015, racial minorities accounted for 2,074).

death associated with childbirth is roughly ten times that associated with abortion.[75] Women who undergo unintended childbirth experience increased risk of maternal depression,[76] and unwanted births carry increased risks of congenital anomalies, premature delivery, and low birth weight.[77]

Arkansas is particularly vulnerable to the risks associated with unwanted pregnancy because the state has a high rate of maternal mortality[78] and many women live at or near the poverty level. Arkansas's maternal mortality rate is 32% above the national average.[79] Depriving this already vulnerable group of women of access to safe, local abortion care effectively forces them to bear the substantial and serious health consequences of unintended pregnancy and childbirth.

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[75] Guttmacher Inst., *State Facts About Abortion: Arkansas* 1 (2015), *available at* https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-arkansas.

[76] Jessica D. Gipson, Michael A. Koenig & Michelle J. Hindin, *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18, 28 (2008).

[77] *Id.* at 24.

[78] Making the Grade on Women's Health: A National State by State Report Card, *Maternal Mortality Rate (per 100,000)*, Nat'l Women's L. Ctr., http://hrc.nwlc.org/status-indicators/maternal-mortality-rate-100000 (last visited Nov. 3, 2016).

[79] *Id.*

3. The Act May Result in Some Women Seeking Unsafe, Illegal Methods to Terminate Their Pregnancies

Limited access to abortion services means that some women are unlikely to be able to obtain safe and legal abortion care[80] and may turn to unsafe, illegal methods to terminate their pregnancies. Limiting access to legal abortion providers does not substantially lower pregnancy rates, nor does it eliminate the need for abortion services.[81] Instead, when access to abortion is compromised, some women will attempt to obtain abortions from unauthorized providers or through self-treatment.[82] These abortions, unlike abortions performed by skilled providers, may pose higher risks of health complications and death.[83] Illegal abortion was a major cause of death and injury for pregnant women in the pre-*Roe*

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[80] *See* Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt. 775, 777 (2011); *see also* Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54, 54 (1995) ("The greater the distance a woman lives from an abortion provider, the less likely she is able to use the provider's services.").

[81] Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 Lancet 625, 625 (2012) (concluding that "[r]estrictive abortion laws are not associated with lower abortion rates"); Guttmacher Inst., *Induced Abortion Worldwide* 1 (2016), *available at* https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide ("Highly restrictive abortion laws are not associated with lower abortion rates.").

[82] *See* Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reprod. Health Matters 136,136 (2010).

[83] Gilda Sedgh et al., *supra* note 81, at 625–26 (listing reasons for higher risks of health complications, including delay in seeking an abortion and lack of appropriate post-abortion care).

era.[84] If the contracted physician provision is permitted to become effective, illegal abortion rates in Arkansas could rise, as will the attendant increased risks of death and injury.

Making abortion more difficult to obtain—with only a single facility in only a single city—imperils the health of women by increasing the incidence of unsafe, illegal abortion, delaying abortion until later in pregnancy, and causing some women to carry unwanted pregnancies to term, with all of the attendant serious risks to health.

CONCLUSION

As described above, the contracted physician requirement lacks any medical basis, fails to increase the quality of medical care for women, and is harmful to the health of women and public health overall in Arkansas. The contracted physician requirement not only places a substantial—and unconstitutional—burden on the exercise of a fundamental right, but threatens to significantly harm the state's public health and welfare.

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[84] Rachel Benson Gold, *Lessons from Before* Roe*: Will Past Be Prologue?*, Guttmacher Rep. on Pub. Pol'y, Mar. 2003, at 8 (noting that the death toll was one "stark indication" that illegal abortions were common).

For these and the foregoing reasons, *amici curiae* APHA and ACOG hereto support Appellees and urge the Court to affirm the District Court's preliminary injunction order.

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a)(7)(C) of the Federal Rules of Appellate Procedure, the foregoing brief is in 14-Point Times Roman proportional font and contains 6,962 words and thus is in compliance with the type-volume limitation set forth in Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure.

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CERTIFICATE OF SERVICE

I hereby certify that on November 9, 2016, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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