No. 23-1275

IN THE

Supreme Court of the United States

ROBERT M. KERR., IN HIS OFFICIAL CAPACITY AS DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioners,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF HEARTBEAT INTERNATIONAL, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

Heartbeat International, Inc. ("Heartbeat") is uniquely positioned to provide relevant factual background and legal argument on a key issue in this case: specifically, that care can be given, through Medicaid and TANF, to organizations that operate in agreement with state desires for the protection of life. Heartbeat is an IRC § 501(c)(3) non-profit, interdenominational Christian organization whose mission is to serve women and children through an effective network of life-affirming pregnancy help centers. Heartbeat serves approximately 3,592 pregnancy help centers, maternity homes, and non- profit adoption agencies (collectively, "pregnancy help organizations") in over 97 countries, including approximately 2,278 in the United States—making Heartbeat the world's largest such affiliate network.

Heartbeat operates a 24/7 toll-free telephone and web-based help line called Option Line, which individuals facing unintended pregnancies can contact for information and referrals to nearby pregnancy help organizations. In 2023, Heartbeat's Option Line handled approximately 395,176 contacts—including phone calls, e-mails, instant messages, and online chats in English and Spanish.

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[1] No counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *Amicus Curiae* or its counsel, make a monetary contribution to the preparation or submission of this brief. The parties were notified of the intent to file this brief on June 28, 2024 and acknowledged receipt of the notice, and declared to have no issues with the timing of the notice.

In the year 2023, Heartbeat connected individuals to pregnancy help organizations an average of once every 76 seconds.

Heartbeat is well positioned to address the healthcare provider issues in this case because it, along with its extensive affiliate network, provides critical support both to parents and their unborn children, including in South Carolina. Heartbeat and its affiliates exemplify the compassionate care that South Carolina envisions its pregnant citizens receive – support for both mother and child.

ARGUMENT

I. Federal code provides each state the authority to qualify providers and defines a process for appeals

Medicaid has always existed as a federal/state partnership, with states having considerable authority to administer Medicaid. States have the authority to direct Medicaid funds in accordance with the guidelines set forth in federal statute.

The provision at issue in this case rests in a section of the Medicaid Act concerning state plans for medical assistance. The Act states that the Secretary of Health and Human Services "shall approve any plan which fulfills the conditions specified in subsection (a)."[2]

Subsection (a), in turn, declares that "[a] State plan for medical assistance must" satisfy some eighty-three conditions. The condition involved here is § 23(A),

[2] 42 U.S.C. § 1396a(b).

namely, that the state plan must "provide that … any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required…who undertakes to provide him such services." [3]

Planned Parenthood and similar respondents assert[4] that the proper mechanism to challenge a state's Medicaid plan is individual suit, but Congress has already specifically stated and provided a remedy for noncompliance. If the state fails to properly qualify or unqualify a care provider, the Secretary of Health and Human Services may withhold the federal funds.[5]

In this way, the decision of compliance properly falls to a Director and Department with experience determining qualifications and with long-standing relationships with the Medicaid programs in the state at issue. This is not only the more prudent method, but also the one built into the original language of the law.

Should the federal government or the Director not affirmatively decide to step into the question of properly qualifying an entity or otherwise enforcing compliance, the statute also grants the *providers* the right to appeal an exclusion from the Medicaid program.[6].

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[3] *Id.* § 1396a(a)(23)(A).
[4] See *Gee v. Planned Parenthood of Gulf Coast, Inc.,* 139 S. Ct. 408 (2018)
[5] 42 U.S.C. § 1396c
[6] 42 CFR 1002.213

Planned Parenthood South Atlantic had a path to appeal outlined, but instead of following the proper route, tried to short-circuit the process by running to the courts. South Carolina provided significant and sufficient reasons for the disqualification of Planned Parenthood South Atlantic.

There are two methods of challenging the state's decision, and neither rests on an individual petitioner. Further, Congress did not intend to create an enforceable right like the one sought here.[7] The law is clearly directed at the relationship between the federal government and the state's application of the federal statute in their federal-state partnership of Medicaid. *Gonzaga,*[8] controlling here, has a requirement of unambiguous intent to create an individual right. Quoting from *Does v. Gillespie;*[9]

> the reference to an "individual" is nested within one of eighty-three subsections and is two steps removed from the Act's focus on which state plans the Secretary "shall approve," 42 U.S.C. § 1396a(b); Congress directly and indirectly established other means of enforcing compliance, 42 U.S.C. § 1396c, 42 C.F.R. § 1002.213; and the substantial compliance funding condition of § 1396c suggests an aggregate focus. Where structural elements of the statute and

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[7] *See Suter v. Artist M.*, 503 U.S. 347, 360-61, 363 (1992), *superseded by statute on other grounds,* 42 U.S.C. 'S'S 1320a-2, 1320a-10; *see also Gonzaga,* 536 U.S. at 281 (applying *Suter*)

[8] 536 U.S. at 281

[9] *Does v. Gillespie,* 867 F.3d 1034 (8th Cir. 2017)

> language in a discrete subsection give mixed signals about legislative intent, Congress has not spoken—as required by Gonzaga, 536 U.S. at 280—with a "clear voice" that manifests an "'unambiguous' intent" to confer individual rights. See John B. v. Goetz, 626 F.3d 356, 361-62 (6th Cir. 2010) (per curiam) (observing that a comparable argument based on the Act as a whole "has considerable support in the language of the statute," but concluding that it was foreclosed by circuit precedent).

This summary from *Gillespie* is ultimately correct and is consistent with the statutory canon of treating the whole text of the statute when reading for meaning. [10] With this view of the law, states, with federal oversight and appeal, have the final determination of which entities should be declared qualified for their Medicaid programs.

As *Gillespie* points out, the alternative forces the state to provide parallel tracks, perhaps ending with disparate results for appeal of any decision on qualification or disqualification of a provider.[11] Not only does this create odd results on the ground, but it would also render the term of "qualified" virtually useless, rather than being settled by the state when determining contracts and partnerships with Medicaid providers.

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[10] Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 167 (2012).

[11] *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017)

II. South Carolina properly unqualified Planned Parenthood because the state determined that continued use of the organization was contrary to the goals of the state

In accord with the proper reading of Section 23(A), South Carolina's governor followed and empowered the will of the state, through both its revised code and voting habits, to cut ties with Planned Parenthood South Atlantic. This was appropriate, as well as consistent with the law.

Executive Order No. 2017-15 further supports South Carolina's position. The order emphasizes the state's culture of protecting the unborn and expresses that state funds appropriated for family planning should not be used to pay for abortions. By reaffirming the policy of denying Title X grant funding to abortion clinics, the state ensures that taxpayer dollars are not indirectly subsidizing abortion-related services. Various governmental and non-governmental entities offer women's health and family planning services without relying on abortion providers, reinforcing the state's commitment to securing appropriate access to actual life-giving family planning services.

A. South Carolinians have the ability to choose from numerous other qualified providers

South Carolina's actions here were well within the bounds of § 23(A) of the Medicaid Act and most fully aligned with its powers as a state. This section examines the state's prerogative to evaluate provider qualifications and the implications of this decision.

B. South Carolina's Prerogative and Provider Qualifications

South Carolina exercised its authority to decertify Planned Parenthood South Atlantic, a decision rooted in its responsibility to manage Medicaid programs effectively, as described above. Under § 23(A), states have the discretion to choose among a range of willing providers and determine whether to deem them qualified for the purposes of Medicaid partnership.[12] This flexibility allows states to tailor their Medicaid programs to meet local needs, ensuring efficient healthcare delivery. The evaluation of provider qualifications is a legitimate and necessary exercise of this authority.

Indeed, South Carolina acted to protect women's health and unborn life, not just with the Governor's executive order, described below, but with state law. The General Assembly has expressed, in section 43-5-1185 of the South Carolina Code of Laws, as amended, that "State funds appropriated for family planning must not be used to pay for an abortion," and paying Medicaid contracts to Planned Parenthood, after it refused to stop performing abortions, would have defeated the will of the legislature.[13]

C. The Ability to Challenge Determinations

Even assuming recipients have a right to choose from qualified providers, any such right does not extend to preserving a specific provider's status once

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[12] 42 U.S.C. 1396a

[13] S.C. Code Ann. § 43-5-1185

decertified. The Supreme Court's decision in *O'Bannon v. Town Court Nursing Center*[14] clarified that § 23(A) grants recipients the freedom to select from a pool of qualified providers. However, once a provider is deemed unqualified, recipients do not retain an enforceable right to continued care from that specific provider.

D. Taxpayer Preferences and Funding Allocation

Perhaps most saliently, South Carolina's decision aligns with the preferences of its taxpayers. As South Carolina Governor McMaster stated, "Most taxpayers in this state do not favor their money being spent on abortions."[15] Indeed, South Carolina and Americans in general are decidedly against taxpayer funding of abortion.[16] South Carolina has the authority to ensure that taxpayer dollars, in the form of Medicaid contracts, are not used to fund abortions.

The decertification of Planned Parenthood South Atlantic reflects the state's commitment to allocating funds responsibly. At the time of decertification, Planned Parenthood received only a fraction of the Medicaid funding the state paid for family planning

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[14] 447 U.S. 773, 1980

[15] Office of the Governor, Executive Order 2017-15, dated August 24, 2017

[16] 60% of Americans were against or strongly against taxpayer funding of abortion.) J anuary 6th through January 9th, 2023 by The Marist Poll. *Available at* https://www.kofc.org/en/resources/communications/polls/2023-kofc-marist-poll-cross-tabs.pdf (visited July 2, 2024)

services.[17] This underscores that the majority of state expenditures in this domain were directed toward other entities, allowing multiple alternative methods for patients to access care.

In addition to the plethora of Medicaid providers in the state, approximately 140 pregnancy help organizations in South Carolina serve pregnant women, offering support including but hardly limited to assisting women in accessing Medicaid and locating appropriate medical care. Pregnancy centers greatly outnumber abortion facilities in South Carolina, as can be seen in Figure 1 below.

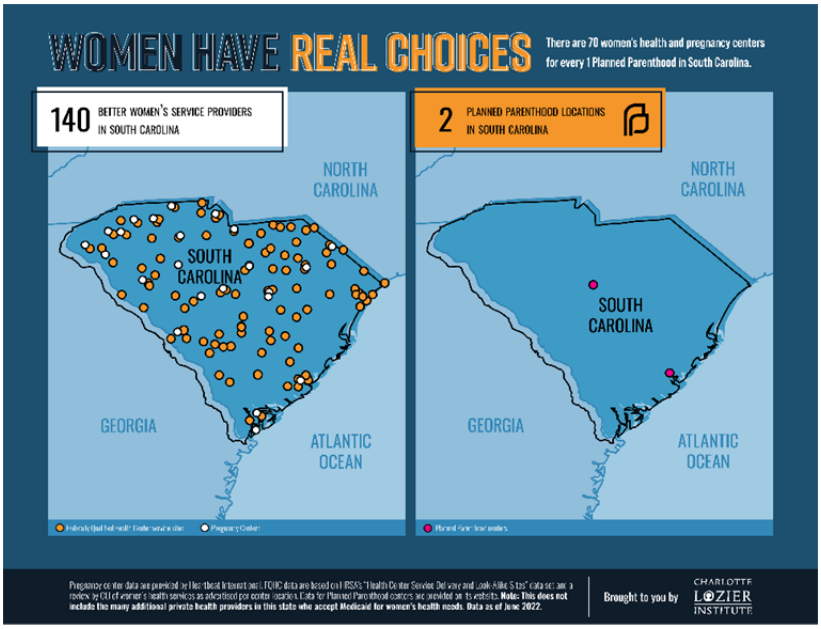

Figure 1: Map of pregnancy centers and Planned Parenthood facilities in South Carolina; Source: Lozier Institute 2024

[17] Executive Order 2017-15

Heartbeat-affiliated pregnancy centers nationally provide, often without state funding and relying upon volunteers and donations, tens of millions of dollars' worth of diapers, ultrasounds, and medical care to women and families in need.[18] Life-affirming pregnancy centers provide relevant health education, parenting classes, medical services, options information, material support, community referrals, and more in compassionate environments.

Nationwide and specifically in South Carolina, pregnancy centers fill a healthcare gap for women and families, where these centers can promote improved health for women, children, and family well-being. In 2022 alone, 2,750 U.S. pregnancy centers conducted over 16 million client sessions (in-person and virtually), provided free material goods and services at a total estimated value of over $367 million, and did so with a national client satisfaction rate of 97.4%. The medical services provided by licensed medical professionals included: 546,683 free ultrasounds and 203,171 STI tests to 104,559 patients. [19] This service delivery was accomplished by over ten thousand licensed medical professionals. (4,779 as paid staff and 5,396 as volunteers).

Many of these pregnancy centers also provide healthcare services including the following:

- breastfeeding consultations are provided at 27% of centers,

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[18] *Available at* https://lozierinstitute.org/wp-content/uploads/2024/05/Pregnancy-Center-2024-Update-full-1.pdf

[19] *Id.*

- STD/STI treatment is provided at 28% of centers,
- abortion pill reversal is provided at 27% of centers,
- and fertility awareness-based methods education are provided at 11% of centers.[20]

The clients of these centers receive, at little or no cost, education and support services, as well, including 409,409 moms and dads attending free parenting classes, 974,965 free consults with new clients, 20,863 women and men receiving free after-abortion support, and 660,064 youth attending free sexual risk avoidance education presentations in group-based settings. The free material items disbursed by pregnancy centers in 2022 included: 3,590,911 packs of diapers, 1,216,438 packs of wipes, 43,192 new car seats, 4,256,274 baby clothing outfits, 30,188 strollers, 23,486 new cribs, and 300,008 new cans/bottles of infant formula[21].

It is eminently reasonable, with the limited reach of Planned Parenthood, coupled with its focus on abortion so out of step with the will of the state of South Carolina, for the state to find better qualified medical providers.

In sum, to the extent an individual right exists in this context, O'Bannon defines it as the ability to choose from among qualified entities, not to choose which entities should be qualified.

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[20] *Id.*
[21] *Id.*

E. Executive Order No. 2017-15

Finally, the Executive Order implementing the cut with Planned Parenthood South Atlantic properly expresses the will of the legislature and the people of South Carolina.

1. Protecting Unborn Life and Fiscal Responsibility:

   The executive order highlights South Carolina's commitment to protecting the life and liberty of the unborn. It acknowledges the state's strong cultural tradition in this regard. Additionally, it emphasizes that state funds allocated for family planning should not be used to support abortion services. By reaffirming this stance, the order aims to maintain fiscal responsibility while safeguarding the sanctity of life.

2. Title X Funding and Abortion Services:

   The order references a specific section of the South Carolina Code of Laws,[22] which prohibits the use of Title X grant funding for abortion services. It underscores the state's position that no abortion-related activities are funded by the South Carolina Department of Health and Environmental Control (DHEC).[23] This reaffirmation ensures that Title X funds are directed exclusively toward non-abortion women's health and family planning services.

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[22] S.C. Code Ann. § 43-5-1185

[23] Executive Order 2017-15

3. Balancing Access and Subsidization:

> Recognizing that abortion providers may receive subsidies from state or local funds intended for broader health services, the order seeks to strike a balance. It acknowledges that various governmental and non-governmental entities offer essential women's health and family planning services without directly or indirectly supporting abortion clinics. By avoiding contracts with abortion providers via Medicaid, South Carolina aims to maintain access to vital services while upholding its principles regarding abortion funding.

In our experience supporting pregnancy centers within South Carolina and throughout the United States, many of our patients have access to Medicaid and work with providers who can and do align with South Carolina's stances.

In summary, South Carolina's decertification decision aligns with its authority under § 23(A) and reflects the responsible allocation of taxpayer funds. Resolving this legal dispute will clarify the limits of recipients' rights and enhance states' ability to engage with Medicaid effectively.

III. RESOLVING THIS CIRCUIT SPLIT IS NECESSARY AND TIMELY

This case has moved through district and appellate courts for years, as have similarly situated parties. There is a mature circuit split, 5-2, on the question of allowing private lawsuits against states rightfully protecting their citizens and tax dollars.

Clarifying that states can unqualify providers without violating recipients' rights will promote consistency and efficiency. States must have the flexibility to engage with Medicaid in a manner that best serves their citizens. A unified approach will enhance healthcare access and quality nationwide.

This case deals with a "conflict on a federal question with significant implications."[24] The question continues, with certain appellate jurisdictions acting under holdings relying on *Wilder*.[25]

While there is a split, it exists primarily due to updates in precedent and the law. *Wilder* has been repudiated. The Court's "repudiation" of *Wilder* is the functional equivalent of "overruling," as the Court uses the terms interchangeably in its opinions.[26] Therefore, those appellate courts relying on *Wilder* should update their jurisprudence, in line with the Eighth and *Gillespie*. This Court now can resolve the circuit split.

For example, the Seventh Circuit in *Planned Parenthood of Ind.* v. *Comm'r of Ind. State Dep't of Health,* 699 F.3d 960 at 976, ruled in favor of Planned Parenthood because "Indiana's position is hard to reconcile with *Wilder*."[27] The other Circuits similarly cited the now-abrogated *Wilder* in

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[24] See *Gee* v. *Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408 (2018) (Thomas, J., dissenting from denial of certiorari).
[25] *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990)
[26] *Obergefell v. Hodges*, 135 S. Ct. 2584, 2606 (2015); *Keene Corp.v. United States*, 508 U.S. 200, 215 (1993); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 864 (1992)
[27] *Planned Parenthood of Ind.* v. *Comm'r of Ind. State Dep't of Health*, 699 F.3d 960 at 976

providing for this individual right to sue.[28] As this area of law was so unsettled and inconsistent, one prescient jurist in concurrence noted that the law may change soon. In *Sabree ex rel. Sabree* v. *Richman,* 367 F.3d 180, 184, 192-93, then-future Justice Alito stated "[w]hile the analysis and decision of the District Court may reflect the direction that future Supreme Court cases in this area will take, currently binding precedent supports the decision of the Court." *Id.* at 194 (Alito, J., concurring). [29]

This Court should grant review and resolve this entrenched split, removing the confusion caused by *Wilder* and still lurking in the legal landscape. This Court should further grant review to resolve the 3-1 split, where certain circuits are ignoring *O'Bannon* and its clear language on the state's authority to determine whether a specific provider is qualified.

As the concurrence in *Gillespie* notes, this Court has already "clearly stated that it was defining the contours of the 'substantive right … conferred by the

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[28] *Harris*, 442 F.3d at 463 ("Our conclusion . . . comports with decisions of the Supreme Court [and other courts] that have recognized privately enforceable rights under § 1983 stemming from similar statutory language in the Medicaid Act.") (citing *Wilder*, 496 U.S. at 510, 524); *seealso Gee*, 2017 WL 2805637, at *9 (following the Sixth and Seventh Circuits); *Betlach*, 727 F.3d at 966-67 (same). The Third Circuit in 2004 similarly relied on *Wilder* in reversing a district court's decision that §§ 1396a(a)(8), 1396a(a)(10), and 1396d(a)(15) did not unambiguously create enforceable rights in light of *Gonzaga*. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 184, 192-93 (3d Cir. 2004).

[29] 367 F.3d 180, 184, 192-93

statutes and regulations.'"[30] The question was whether a patient had the right to force the state to continue considering the nursing home qualified and therefore provide coverage for the patient. To quote *Gillespie*'s treatment of *O'Bannon:*

> Medicaid recipients have the enforceable right to a range of qualified providers. So state agencies cannot steer patients to certain qualified providers at the expense of other qualified providers. Nor can an agency artificially create a monopoly in Medicaid care.[8] But there exists no right to a particular provider the State has decertified. Second, § 23(A) does not give Medicaid recipients the right "to challenge *the merits* of a State's assertion that a provider of Medicaid services is no longer qualified to provide Medicaid services or to challenge the State's termination of a provider's Medicaid agreements on the basis of the provider's noncompliance with state and federal regulatory requirements."[31]

The circuits are split, with the Fifth Circuit's *en banc* opinion in *Kauffman* creating an irreconcilable distinct reading of *O'Bannon* with the others.[32] Granting review for this petition would further solidify the precedent, removing ambiguity, and providing proper balance between the federal and

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[30] O'Bannon, 447 US at 786, within Gillespie at 21

[31] *Gillespie* treating *O'Bannon* and citing ." PlannedParenthood of Gulf Coast, Inc. v. Gee, No. 15-30987, 2017 WL 2805637, at *20 (5thCir. June 29, 2017)

[32] Kauffman

state governments in their application of Medicaid funding. This will allow states to administer their Medicaid programs in a manner consistent with their values.

CONCLUSION

For the reasons stated above and in the briefing of Petitioners, the Court should grant cert and resolve the circuit split, ensuring that it correctly answers the important question presented by this case.

Respectfully submitted,

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JULY 03, 2024

Appendix

Charlotte Lozier Institute,
Hope for a New Generation (2024)


PREGNANCY CENTERS OFFER
HOPE
FOR A NEW
GENERATION
Updated May 2024
A Legacy of LIFE & LOVE Report Series
A collaboration of Charlotte Lozier Institute, Care Net, Heartbeat International,
and National Institute of Family and Life Advocates

THE POWER TO SERVE IS THE POWER TO SAVE LIVES. TO TRANSFORM MINDS AND HEARTS.

Fifteen years ago, a group of pregnancy help center leaders gathered in Washington, D.C. to find even better ways to serve. The United States, the richest and most powerful nation on Earth, was falling prey to more than 1,200,000 abortions per year, with no end in sight.

Then as now, there was no real way to calculate the immensity of this human loss. The leaders realized how much more needed to be done. They resolved, as champions of mothers, babies, and families, to produce a national report on their combined resources. They realized the magnitude of the tasks before them and that they were, every day and always, "better together" as they strove to defend the most vulnerable in our midst.

Since that summit meeting, five national reports have been produced – this one being the fifth. The work of many hands, **Hope for a New Generation** follows similar publications by Family Research Council in 2009 and 2011 and by a growing coalition of center networks in 2018, 2020, and today. With each edition, more centers and networks have contributed their service numbers and accounts of their love-giving and lifesaving interactions with their clients.

Besides the growth in centers, and the narrative of a largely private-sector movement of professionals and volunteers, these reports document how pregnancy help centers have identified and responded to an array of challenges. Such issues as human trafficking, homelessness, domestic abuse, sexually transmitted disease morbidity, and abortion pill regret and reversal have prompted new resilience and response. Centers continue to innovate and connect with a panoply of community services to promote maternal, child and family health and well-being.

Now, in the wake of the reversal of the infamous *Roe v. Wade*, the demands upon centers are increasing daily. Many states are responding with new funds and new policies to support the centers' work. New attacks, by violent radicals and by politicians who should know better, are launched daily.

Some would find these challenges daunting. But as **Hope for a New Generation** shows, pregnancy center leaders see in this situation new opportunities to serve. We are prouder than ever to bring these accounts to you with the promise, God willing, of more to come.

Please find us at lozierinstitute.org/pcr

CHARLOTTE LOZIER INSTITUTE

NIFLA

CARENET

Heartbeat INTERNATIONAL

Sincerely,

Chuck Donovan

President, Charlotte Lozier Institute

2022

NEW METRIC FOR PREGNANCY CENTER WORK FOR 2022 AT 2,750 US CENTERS

Total # of Client Sessions, In Person and Virtual	16,050,312

Client Satisfaction

Percent Client Positive Experience/Satisfaction (self-reported)	97.4%

Consolidated Table of Pregnancy Help Services and Support 2022

US Clients Served		Estimated Value of Free Services*
Consulting with new clients	974,965	$30,165,417
Free pregnancy tests	703,835	$6,334,515
Free ultrasounds performed	546,683	$136,670,750
RN/RDMS hours performing ultrasounds	546,683	$22,791,214
STD/STI tests performed	203,171	$5,688,788
RN hours meeting with STD/STI test clients	104,559	$4,475,125
Clients attending parenting education programs	409,409	$76,002,687
Clients receiving after-abortion support	20,863	$3,227,506
Students attending sexual risk avoidance education	660,064	$3,960,384
Material Goods		**Dollar Value of Free Goods**
Pack of diapers	3,590,911	$40,218,203
Pack of wipes	1,216,438	$3,649,314
Baby clothing outfits	4,256,274	$21,281,370
Containers of baby formula	300,008	$6,000,160
New Car Seats	43,192	$3,455,360
New Cribs	23,486	$3,522,900
Strollers	30,188	$452,820
TOTAL VALUE OF SERVICES & GOODS		**$367,896,513**

*A small percentage of medical centers charge a low-cost fee for STD/STI testing. For individual estimates of value of goods and services visit Hope for a New Generation at lozierinstitute.org/pcr

2022

Staff and Volunteers

Category	2022 Total	Percent
Paid staff	17,646	
Licensed medical staff	4,779	27.1%
Total volunteers	44,930	
Licensed medical volunteers	5,396	12.0%
Total paid and volunteer staff	62,576	71.8% of workers are volunteers

Percentage of Centers Offering Selected Services

Service Category	Centers Offering	Percent
Ultrasound	2,248 of 2,750	81.7%
Parenting/Prenatal Education	2,411 of 2,750	87.7%
After-Abortion Support/Recovery	1,974 of 2,750	71.8%
Material Items	2,454 of 2,750	89.2%
STD/STI Testing	988 of 2,750	35.9%
STD/STI Treatment	776 of 2,750	28.2%
Lactation/Breastfeeding Consults	742 of 2,750	27%
Fertility Awareness-Based Methods	314 of 2,750	11.4%
Sexual Risk Avoidance Presentations to Youth	621 of 2,750	22.6%
Abortion Pill Reversal	738 of 2,750	26.8%
Trained Outreach to Victims of Trafficking	253 of 1,484**	17.0%

**Data for this outreach was collected for only one of the two data sets analyzed in this study.

Some results are updated from the December 2023 release, as new data was received in early 2024.

"I was ready to give up on my baby's life because I wasn't emotionally or financially prepared. I felt lonely and hopeless. My personal advocate spoke words of hope and encouragement. I then met with a counselor and she helped me see that I had other options and resources available. After I spoke with them both, I had a renewed confidence to keep my baby. Every time I came in for a prenatal appointment or a class, I felt so loved and supported and that continued to give me hope."

– LAS VEGAS, NEVADA

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info@lozierinstitute.org | 202-223-8073 | www.lozierinstitute.org

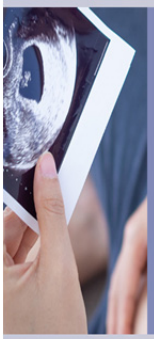
CHARLOTTE LOZIER INSTITUTE

HOPE FOR A NEW GENERATION

A LEGACY OF LIFE & LOVE REPORT SERIES

Over 2,750 pregnancy resource centers (PRCs) in the U.S. served families with material goods and services valued at $367 million in 2022.

- The estimated total value of goods and services provided by PRCs (incl. ultrasounds, education, health care, diapers, baby formula, and much more) was $367,896,513, an over $100 million increase since 2019.
- The total number of both in-person and virtual client sessions was 16,050,312.
- More than 8 in 10 PRCs are providing medical services.
- 97.4% of pregnancy center clients reported a positive experience/satisfaction.



Between 2019 and 2022, there were notable percent increases at PRCs:

- +41% growth in attendees for parenting and prenatal education programs
- +27% jump in STD/STI tests provided
- +194% increase in material services/baby items delivered (two previously unreported categories, new cribs and infant formula, were included in this report)

There are over 60,000 paid and volunteer staff working at PRCs nationwide.

The estimated total value of free health care, education, support services and items provided by PRCs surpassed $360 million.

- *Free medical services had an estimated value of $175,960,392
- 881 centers reported serving a total of 17,696 women after they took abortion drugs.
- The following health care services continue to grow: lactation/breastfeeding consultations, STI testing and treatment, and fertility awareness-based methods.
- Free education and support services had an estimated value of $113,355,994.
- 409,409 moms and dads attended prenatal and parenting education programs, at an est. value of $76,002,687.
- The distribution of free material resource items to 808,737 people had an estimated value of $78,580,127.

*a fraction of centers charge a low fee for STI testing

Client advocate session onboard an Image Clear Ultrasound Mobile (ICU Mobile) medical mobile unit in Akron, Ohio.

Maternity homes have nearly doubled in four years.

- The number of PRCs operating a maternity home almost doubled from 24 to 46 between 2019-23, according to the Maternity Housing Coalition.
- In 2023, an additional 35 start-up homes have been recorded by MHC at PRCs.

More women have access to Abortion Pill Reversal (APR) to continue their pregnancies after taking the abortion drug, mifepristone.

A medical provider will prescribe APR, which is natural progesterone, to reverse the effects of mifepristone which blocks progesterone. Considering progesterone has been used to support healthy pregnancies since the 1950s, APR is a **safe** **effective** protocol which has given women a chance to continue their pregnancies.

- APR saved over 5,000 children's lives after mothers regretted taking the abortion drug between 2012-23, according to the Abortion Pill Rescue Network.
- There was a 142% increase in PRCs providing and overseeing the APR protocol and providing resources and support for women following drug-induced abortions between 2019-22.

HOPE FOR A NEW GENERATION

A collaboration of Charlotte Lozier Institute, Care Net, Heartbeat International, National Institute of Family and Life Advocates, and Option Ultrasound Program by Focus on the Family