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Brief of Amici Curiae National Health Law Program and National Network of Abortion Funds Supporting Petitioners-Cross-Respondents

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In the
Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., ET AL.,
Petitioners–Cross-Respondents,
v.

REBEKAH GEE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,
Respondent–Cross-Petitioner.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM AND NATIONAL NETWORK OF ABORTION FUNDS SUPPORTING PETITIONERS–CROSS-RESPONDENTS

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The National Health Law Program ("NHeLP"), founded in 1969, protects and advances health rights of low-income and underserved individuals and families. NHeLP engages in education, litigation, and policy analysis to advance access to quality health care, including the full range of reproductive health care services, and to protect and vindicate health and civil rights in the United States.

The National Network of Abortion Funds ("NNAF") is a 27-year-old organization that builds power with members to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice. With over 70 member organizations and over 13,000 volunteers across the United States and abroad, NNAF is working to ensure that every reproductive decision is supported and free from coercion. We advocate for all people to have the power, autonomy, and resources to care for and affirm their bodies, identities, and health for themselves and their families in all areas of their lives. We center those who have abortions and oppose any and all discrimination, violence, and coercion impacting women, people of color, immigrants, people with low incomes, and the lesbian, gay, bisexual, transgender,

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[1] Pursuant to Rules 37.3 and 37.6, all parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici* and *amici*'s counsel, contributed money intended to fund preparation of submission of this brief.

queer, and gender non-conforming people ("LGBTQ-GNC") community.

Amici are deeply concerned about Act 620, the Louisiana law at issue here.

SUMMARY OF ARGUMENT

By enacting an unconstitutional admitting-privileges requirement, Louisiana has constructed an imposing, and in some cases impossibly high, impediment to those seeking abortion care in the state. If allowed to go into effect, the requirement will force the closure of clinics that provide vital abortion care. The ill effects of Act 620 ripple outward and compound one another, particularly for marginalized and vulnerable populations. Having fewer clinics in operation will force people to travel longer distances to reach care, which will in turn drive up costs due to increased attendant expenses and delays.

As the district court held, the harmful effects of the requirement will be felt exponentially by low-income Louisianans—many of whom will not be able to access abortion care should the law be implemented. Poverty rates in Louisiana are the third highest in the nation. Communities of color, survivors of intimate partner violence, and LGBTQ-GNC people are even more likely to live in poverty—and, thus, more likely to experience Act 620 as a practical ban on their right to have an abortion.

Poverty exacerbates the rippling burdens caused by the admitting-privileges law, as low-income pregnant people are more likely to need abortion care and less likely to be able to afford the service once access is

decimated. The costs of obtaining abortion care are prohibitively high for low-income people who often delay care while trying to pull together the necessary funds. Bans on insurance coverage of abortion care further compound the burdens of the law; in Louisiana, neither the federal nor the state Medicaid program covers abortion care, except in extremely rare cases. Yet, ironically, it is often the inability to financially care for a child that drives the need for abortion care, creating a cruel double bind.

The severe burdens imposed by Act 620 elevate the financial hurdles to abortion access already experienced by pregnant Louisianans living in poverty. The majority must pay out-of-pocket for abortion care, and the costs are prohibitively high for a person living below the poverty level. A first-trimester abortion in Louisiana costs $500, yet a person making minimum wage in Louisiana earns $1,208 per month. Moreover, abortion care often results in attendant costs, including lost wages, child care, gas, or overnight stays. This forces low-income pregnant Louisianans to either forgo the necessities of life, including food, medicine, and housing, to cover the out-of-pocket costs of an abortion, or carry a pregnancy to term.

When abortion access is limited by medically unnecessary requirements like Act 620, people will be forced to carry pregnancies to term, thereby imperiling their health and lives due to the risks associated with pregnancy, labor, and delivery. The negative economic consequences are grave, potentially dooming a person to long-term poverty. Again, low-income people of color and LGBTQ-GNC people are more profoundly and

more commonly impacted by the perilous combination of restrictions on abortion provision and bans on its coverage, due to disproportionate rates of poverty in these communities.

ARGUMENT

I. Louisiana's admitting-privileges requirement imposes an undue burden that will disproportionately impact vulnerable populations in need of abortion care.

A. Pregnant people living in poverty in Louisiana will be among the groups most encumbered by Act 620.

Louisiana's admitting-privileges law ("Act 620") requires a physician to hold "active admitting privileges" at a hospital within 30 miles of the facility where abortion care is provided. La. Rev. Stat. § 40:1061.10(A)(2)(a). Act 620 is identical to the law struck down by the U.S. Supreme Court in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). Like the law at issue in that case, Act 620 places an undue burden on the right to abortion care. If it is implemented, the attendant costs of seeking abortion care will increase as pregnant people are forced to travel farther to obtain abortion care, incurring greater transportation and childcare costs, and losing more wages due to time off work. *June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 82-84 (M.D. La. 2017). This will disproportionately burden low-income and other vulnerable people. Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, __ J. Women's Health __ (2019) (finding that

greater travel distance to reproductive healthcare clinics results in greater out-of-pocket costs); *see also* Sarah C.M. Roberts et al., *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 Contraception 368, 371 (2015) (finding that Act 620 likely to increase the travel distance to obtain abortion care, imposing greater burdens on more vulnerable people) (hereinafter "Roberts et al., *Implications for Women*").[2]

1. The district court found that Act 620 imposes a severe burden that will fall most heavily on poor and low-income people.

In addressing the constitutional challenge to Act 620, the district court found that the admitting-privileges law accomplishes "little or nothing for women's health" and that people seeking abortion care in Louisiana "w[ould] face substantial obstacles in exercising their constitutional right to choose abortion due to the dramatic reduction in abortion services" that would result from Act 620. *June Med. Servs. LLC*, 250 F. Supp. 3d at 84, 88. The district court noted that "[i]t is plain that Act 620 would result in the closure of clinics, fewer physicians, longer waiting times for appointments, increased crowding and increased

[2] In 2017, without the harmful admitting-privileges requirement in place, 72 percent of Louisiana women already lived in parishes that had no clinics offering abortions, requiring them to travel often significant distances to access abortions. Guttmacher Inst., *State Facts About Abortion: Louisiana* (Sept. 2019), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana.

associated health risks." *Id.* at 81. In particular, the district court found that as a result of Act 620, there would be only one abortion provider left in Louisiana to serve approximately 10,000 patients per year—which the court found would be an impossible task. *See id.* at 80, 87-88. Based on these factual findings, the district court concluded that "approximately 70% of the women in Louisiana seeking an abortion would be unable to get an abortion in Louisiana." *Id.* at 80 (footnote omitted).

While the district court found that all people seeking abortion care in Louisiana would face substantial obstacles "due to the dramatic reduction in the number of providers and the overall capacity for services," evidence in the record confirmed that the "heaviest burdens of Act 620 would fall disproportionately upon poor women." *Id.* at 82. The district court's findings of fact highlighted that as a result of Act 620's decimation of providers in Louisiana, many more patients would be forced to travel significant distances to reach an abortion care provider, which imposes severe burdens that "will fall most heavily on low-income women." *Id.* at 88. The record established that "[i]ntercity travel for low-income women presents a number of significant hurdles, including the logistics and cost of transportation, the costs associated with time off from work, and childcare costs" and lack of access to a vehicle. *Id.* at 83. As the district court succinctly summarized, "Act 620 would do little or nothing for women's health, but rather would create impediments to abortion, with especially high barriers set before poor, rural, and disadvantaged women." *Id.* at 84. If anything, these burdens would

increase health risks to people seeking abortion care, especially for poor and low-income pregnant people. *See id.* This is a particularly pernicious outcome when people living in poverty are the group more likely to need abortion care.

2. Louisiana's poverty rates are high, and abortion rates are higher among people living in poverty.

Nationally, low-income people have the highest rates of abortion. People with incomes less than 100 percent of the federal poverty level accounted for almost half of all abortion patients in 2014. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 2008–2014, Am. J. of Pub. Health (Dec. 2017), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042 (hereinafter "Jones & Jerman, *Population Group Abortion Rates*"). Nationally, 49 percent of people seeking abortion care live in poverty. *See* Rachel K. Jones et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients, 2008* (May 2010), https://www.guttmacher.org/pubs/US-Abortion-Patients.pdf (hereinafter "Jones et al., *Characteristics of U.S. Abortion Patients*"). As income levels increase, the abortion rate decreases, with women in the highest income bracket experiencing an abortion rate less than half the national rate. Jones & Jerman, *Population Group Abortion Rates* (noting that the abortion rate for women in the highest income group is 6.0 per 1,000).

While there are no specific data about the proportion of people seeking abortion care in Louisiana who are poor, it is likely at least as high—if not higher—than the national proportion. For example, statistics on people seeking abortion care in Louisiana reveal that 47 percent had only some education beyond high school, and one in seven (14 percent) had not completed high school. Roberts et al., *Implications for Women*. The correlation between education level and poverty suggests that many of those seeking abortion care whose highest scholastic achievement is a high school diploma or less are very likely to be poor or low income. Center for Poverty Research, Univ. of Cal. Davis, *How Does Level of Education Relate to Poverty?* https://poverty.ucdavis.edu/faq/how-does-level-education-relate-poverty (last visited Nov. 25, 2019).

Moreover, Louisiana ranks as the third poorest state in the United States, with one in five residents living in poverty. *See* La. Budget Project, *Louisiana's Poverty and Child Poverty Rates Remain High* (Sept. 18, 2014), http://www.labudget.org/1bp/2014/09/louisianas-poverty-and-child-poverty-rates-remain-high. Because abortion rates are higher among people living in poverty, common sense dictates that Louisianans living in poverty disproportionately need access to abortion care and will disproportionately face severe burdens as a result of Act 620.

a. Higher rates of unintended pregnancy increase the need for abortion care among people living in poverty.

There is a high correlation between poverty and unintended pregnancy. A person living in poverty is more than five times as likely as one not living in poverty to experience an unintended pregnancy. *See* Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 Contraception 478, 483 (2011), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/ (noting that people below 100 percent of the poverty line experience unintended pregnancy at a rate of 130 per 1,000 people compared with 90 per 1,000 people above 200 percent of the poverty line). Medicaid beneficiaries, who are by definition poor and low income, are more likely to experience gaps in contraception use that put them at risk of unintended pregnancy than those with other forms of insurance. Jennifer J. Frost et al., *Factors Associated with Contraceptive Use and Nonuse, United States, 2004*, 39 Perspectives on Sexual & Repro. Health 90, 93 (2007). Given that people living in poverty are more likely to experience unintended pregnancy, and a significant proportion of unintended pregnancies end in abortion, it is no surprise that poor people also represent a large share of abortion seekers. *See* Jones et al., *Characteristics of U.S. Abortion Patients*.

b. Poor and low-income people often seek abortion care because they cannot afford to financially support a child.

Economic insecurity and the inability to financially care for a child drive many poor and low-income pregnant people to seek abortion care. Nationally, about 73 percent of patients indicate that their reason for seeking abortion care is because they cannot afford to have a child. Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual & Repro. Health 110 (2005); *see also* M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC Women's Health 29 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3729671/.

Nationally, almost 60 percent of people seeking abortion care are already parenting at least one child. *See* Karen Pazol et al., Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2009*, 61 MMWR Surveill. Summ. 1, 7 (Nov. 23, 2012), http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6108al.htm. In Louisiana, almost three-fourths of the people seeking abortion care were already parenting at least one child. Roberts et al., *Implications for Women.* Louisiana's child poverty rate is the third highest in the nation, with 29 percent of its children living in poverty. *See* Children's Defense Fund, *State of America's Children 2017* (2017), https://www.childrensdefense.org/wp-content/uploads/2018/06/2017-soac.pdf. One in eight of

its children live in extreme poverty, defined as at or below 50 percent of the poverty level. *Id.*

The high rates of poverty in Louisiana, combined with evidence that financial hardship is a significant reason people seek abortion care, reveals that abortion care access is a critical means of keeping families from slipping further into poverty.

B. Adverse effects of Act 620 will be visited unduly upon low-income people of color, LGBTQ-GNC people, and people experiencing intimate partner violence.

Laws like Act 620 that shut down clinics make it harder for people of color, LGBTQ people, and survivors of intimate partner violence to get abortion care when they need it.

1. People of color in Louisiana are disproportionately likely to be living in poverty and more likely to need abortion care.

Louisianans of color are both disproportionately poor and more likely to need abortion care for a variety of reasons. Act 620 will especially harm Louisianans of color by making abortion care even more difficult to access.

a. Poverty rates are higher among communities of color in Louisiana and nationwide.

Nationally, people of color are disproportionately poor. According to 2018 census estimates, 22.5 percent of African Americans and 18.8 percent of Latinx individuals are living below the poverty level, compared with only 9.5 percent of whites and 10.8 percent of Asian Americans. U.S. Census Bureau, Poverty Status in the Last 12 Months, https://data.census.gov/cedsci/table?q=poverty%20rates%20asian%20pacific%20islander&hidePreview=false&table=S1701&tid=ACSST1Y2018.S1701&t=Native%20Hawaiian%20and%20Pacific%20Islander%3AAsian%3APoverty&lastDisplayedRow=30. Moreover, certain groups of Asian Americans face much higher poverty rates than are reflected in the aggregate census data. For example, 13.9, 17.7, and 13.3 percent of people of Laotian, Hmong, and Cambodian descent, respectively, live in poverty in the United States. U.S. Census Bureau, Selected Population Profile in the United States, https://data.census.gov/cedsci/table?q=&lastDisplayedRow=181&table=S0201&tid=ACSSPP1Y2018.S0201&t=015%20-%20Cambodian%20alone%20%28405-409%29%3A020%20-%20Hmong%20alone%20%28422%29%3A024%20-%20Laotian%20alone%20%28442%29%3APoverty&g=0100000US&hidePreview=false&vintage=2018&layer=state&cid=S0201_001E.

Poverty rates among many communities of color in Louisiana are even higher than the national averages, and the disproportionality of some racial minorities' poverty rates is even more pronounced in Louisiana than nationwide. The poverty rate for African Americans in Louisiana is nearly triple that of whites, with 32.9 percent living in poverty compared to 12.5 percent of white Louisianans. Welfare Info, *Louisiana Poverty Rate by Race*, (2017), https://welfareinfo.org/poverty-rate/louisiana/#by-race. The poverty rate for Latinx people living in Louisiana is more than double for whites, with 25.1 percent of Latinx people in Louisiana living in poverty. *Id.* Nearly 25 percent of Native Americans and 16 percent of Asian Americans in Louisiana live in poverty. *Id.*

b. African Americans residing in Louisiana are more likely than white residents to need abortion care.

In particular, African Americans in Louisiana are significantly more likely to both live in poverty and need access to an abortion. Roberts et al., *Implications for Women*. In Louisiana, almost two-thirds of the people accessing abortion care in 2013 were African Americans. *Id.* This is significantly higher than the national average, which is already elevated. African American women account for 28 percent of all abortions in the United States but represent just 13 percent of the U.S. female population. Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (May 2016), *http://www.guttmacher.org/report/characteristics-us-*

abortion-patients-2014; Maria Guerra, Center for American Progress, *Fact Sheet: The State of African American Women in the United States* (November 2013), https://americanprogress.org/issues/race/reports/2013/11/07/79165/fact-sheet/the-state-of-african-american-women-in-the-United-States. African Americans seeking abortion care are significantly more likely to live in poverty than their white counterparts (50 percent compared to 24 percent of abortion seekers who were white). J. Kotting & G.E. Ely, *The Undue Burden of Paying for Abortion: An Examination of Abortion Fund Cases* 2 (2017).

c. Unintended pregnancy is more common among communities of color, contributing to higher than average abortion rates.

At the same time, people of color have comparatively higher rates of unintended pregnancies at all income levels, and are therefore more likely to seek abortion care. *See, e.g.*, Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 New Eng. J. Med. 843 (2016). The need for abortion care is likely compounded for low-income people of color. Black, Latinx, and Asian American women, regardless of income, are also more likely to experience gaps in contraception use that put them at greater risk of unintended pregnancy than white women. Frost et al., *supra*, 39 Perspectives on Sexual & Repro. Health at 93. Studies have attributed those barriers to contraception access to the cost associated with

obtaining contraception, combined with funding cuts to programs that provide free and low-cost contraception to low-income communities of color, and low numbers of reproductive healthcare providers in low-income communities and communities of color. *See, e.g.,* Alisa Von Hagel & Daniela Mansbach, Scholars Strategy Network, *The Abortion Barriers and Needs of Black Women* (Apr. 26, 2018), https://scholars.org/brief/abortion-barriers-and-needs-black-women (collecting research). People of color are also more likely to have had negative and racist encounters with medical providers that can lead to distrust; these factors may also influence the racial disparities in unintended pregnancies. *See id.*; Christine Dehlendorf et al., *Racial/Ethnic Disparities in Contraceptive Use*, 210 Am. J. Obstet. Gynecol. 526e1 (2014). As a result, people of color, especially those who are low income, are likely to need abortion care.

2. LGBTQ-GNC people are more likely to be living in poverty and to need access to abortion care.

Nationally, LGBTQ-GNC people are more likely to live in poverty than are heterosexual and cisgender people. M.V. Lee Badgett et al., Williams Inst., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* 2 (2013) (hereinafter "Badgett et al., *New Patterns of Poverty*"); *see also* Jennifer Russomanno et al., *Food Insecurity Among Transgender and Gender Nonconforming Individuals in the Southeast United States: A Qualitative Study*, 4 Transgender Health 89 (2019). These differences are even starker for certain

subpopulations of LGBTQ-GNC people. For example, bisexual women in particular have a poverty rate of almost 30 percent, nearly double that of the general population. Badgett et al., *New Patterns of Poverty* at 2. African Americans in same-sex couples are at least twice as likely to be low income than different-sex married African Americans, and are more than six times more likely to have low incomes than white men in same-sex couples. *Id*. A 2016 study found that transgender individuals also are twice as likely to be living in poverty as the general U.S. population, with 29 percent reporting poverty in 2015. Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 144 (2016), http://www.ustranssurvey.org/reports.

At the same time, bisexual women experience unintended pregnancy at rates equal to, if not higher than, their heterosexual peers. Bisexual women have a higher rate of unintended pregnancies than women who only have sexual relationships with men. Bethany G. Everett et al., *Sexual Orientation Disparities in Mistimed and Unwanted Pregnancy Among Adult Women*, 49 Perspectives on Sexual & Repro. Health 157, 161 (2017). And, presumably, members of this group end unintended pregnancies at rates consistent with the national average. Caroline S. Hartnett et al., *Congruence across Sexual Orientation Dimensions and Risk for Unintended Pregnancy among Adult U.S. Women*, Women's Health Issues (2016).

3. Survivors of intimate partner violence who become pregnant need access to abortion care.

a. Intimate partner violence is prevalent in Louisiana and nationwide.

People throughout Louisiana and the country experience high rates of intimate partner violence. S.G. Smith et al., National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report* 120 (2017) ("*NISVS*") (nearly one in four U.S. women will experience severe intimate partner violence in her lifetime). While all people are affected by intimate partner violence, *id.* at 2-3, the majority of this violence is perpetrated by men against women. Matthew R. Durose et al., *Family Violence Statistics: Including Statistics on Strangers and Acquaintances*, U.S. Department of Justice, Bureau of Justice Statistics 1 (2005). Statistics in Louisiana reflect the national picture. NISVS, *supra*, at 119. By one grim measure they are worse: Louisiana is ranked second among all states in murders of women by men, and the majority of those murders are committed by their current or former male partners. Violence Policy Center, *When Men Murder Women: An Analysis of 2017 Homicide Data* 4 (2011).

b. People of color experience intimate partner violence at higher rates than white people do.

Intimate partner violence is an even more common experience for women of color: four in 10 black and Native American women, and one in two multiracial women, will be raped, physically assaulted, or stalked by an intimate partner in their lifetime. Michele C. Black et al., National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* (2011), http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf; *see also* Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109-162, Title II, § 201(1) 2-3, 119 Stat. 2960 (2006).

c. Poverty can increase the likelihood of intimate partner violence and trap survivors in abusive relationships.

People from every walk of life experience intimate partner violence; however, poverty is associated with an increased rate of partner abuse. *See* Martha Davis, "The Economics of Abuse: How Violence Perpetuates Women's Poverty" *in Battered Women, Children, and Welfare Reform: The Ties That Bind* 17 (Ruth Brandwein ed., 1999). Poverty imposes numerous barriers to leaving violent relationships. One of the most significant barriers is having children with the abusive partner. *See, e.g.,* Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic*

Violence on Child Custody Decisions, 44 Vand. L. Rev. 1041, 1051 (1991) (describing legal difficulties that arise for survivors of intimate partner violence when leaving with children and their reluctance to flee without them).

d. Unintended pregnancy is a high risk in abusive relationships and gives rise to the need for access to abortion care.

Unfortunately, unintended pregnancy is a risk of intimate partner violence because abusers frequently use "reproductive coercion" as a tool of control over their intimate partners. Reproductive coercion describes a spectrum of conduct, ranging from rape to sabotaging birth control, used primarily to force pregnancy. Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316 (2010); *see also* Anne M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737 (2010). Although reproductive coercion may take place in a non-violent relationship, in the context of intimate partner violence the prevalence is higher, the severity is higher, and the risk of unintended pregnancy is doubled. Jonel Thaller & Jill Theresa Messing, *Reproductive Coercion by an Intimate Partner: Occurrence, Associations, and Interference with Sexual Health Decision Making*, 42 Health & Soc. Work e11 (2016); *see also* American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Committee Opinion No. 554: Reproductive and Sexual Coercion* 2

(Feb. 2013), www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co554.pdf?dmc=1&ts=20151228T1259486661.

II. The severe burdens imposed by Act 620 will exacerbate the steep financial hurdles to abortion access already experienced by pregnant people living in poverty.

What all the groups discussed above, and indeed all people living in poverty, face is that they often lack the financial resources needed to pay for abortion care and its related costs. Laws like Act 620 that force people to either entirely forgo abortion care or force them to wait significantly longer to obtain abortion care increase the costs of that care and, therefore, exacerbate the burdens.

A. Due to abortion coverage bans on insurance, most people in Louisiana and throughout the country must pay out-of-pocket for abortion services.

In Louisiana, most health coverage programs do not cover abortion care, so pregnant people must try to pay for abortion services out-of-pocket.

1. Although Louisianans rely on Medicaid more than any other source of health insurance, coverage bans force them to pay out-of-pocket for abortion care.

The most common source of healthcare coverage for low-income people is the Medicaid program, which covers more than 65 million Americans and nearly 1.3 million Louisianans. Centers for Medicare & Medicaid

Services, *August 2019 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Nov. 25, 2019). In fiscal year 2018, more than 450,000 women between ages 15 and 44 were enrolled in Louisiana Medicaid. Louisiana Dep't of Health, *Louisiana Medicaid: 2018 Annual Report* 36, tbl. 16, http://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2018_v4.pdf.

Medicaid has not covered the vast majority of abortions since Congress first passed the Hyde Amendment in 1976. The Hyde Amendment prohibits federal Medicaid coverage of abortion care except when a rapist or child molester caused the pregnancy or when the pregnancy could kill the pregnant person. Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3118, §§ 506-07 (2018). Henry Hyde, the sponsor for whom the amendment is named, laid bare his intent to forestall poor people from obtaining abortion care, stating:

> I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the . . . Medicaid bill.

123 Cong. Rec. 19,700 (1977) (statement of Rep. Hyde).

In the decades since its original passage, economic and reproductive justice advocates and scholars have argued that the Hyde Amendment's purpose and effect was to stop people living in poverty from having abortions, thereby stripping them of their constitutionally protected reproductive rights.[3] In 1980, a slim U.S. Supreme Court majority rejected a challenge to the legality of the Hyde Amendment and further held that states have no independent obligation to cover medically necessary abortions. *Harris v. McRae*, 448 U.S. 297, 308 (1980).

2. People of color and LGBTQ individuals are more likely to be enrolled in Medicaid and, therefore, to lack insurance coverage of abortion.

People of color are especially likely to be enrolled in Medicaid and therefore lack coverage for most abortion care. For example, nationally 31 percent of black women of reproductive age and 27 percent of Latinx women of reproductive age are enrolled in Medicaid, as compared with 16 percent of their white counterparts. Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, 20 Guttmacher Pol'y Rev. 39, 40 (2017). Nearly one-fifth

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[3] *See* Reproductive Health Technologies Project, *Two Sides of the Same Coin: Integrating Economic and Reproductive Justice* (Aug. 2015), http://rhtp.org/wp-content/uploads/2016/08/Two-Sides-of-the-Same-Coin-Integrating-Economic-and-Reproductive-Justice.pdf; Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting* Harris v. McRae, 21 Wm. & Mary J. Women & L. 5 (2014).

(19 percent) of Asian American and Pacific Islander women are enrolled in Medicaid. In Our Own Voice et al., *Attacks on the Affordable Care Act, Planned Parenthood and Medicaid Are Attacks on Reproductive Justice for Women of Color* (Sept. 2017), http://www.nationalpartnership.org/our-work/resources/repro/attacks-on-the-affordable-care-act-planned-parenthood-and-medicaid-are-attacks-on-reproductive-justice-for-women-of-color.pdf.

Nationally, nearly 1.2 million LGBTQ adults are estimated to be enrolled in Medicaid. Kerith J. Conron & Shoshana K. Goldberg, Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (Jan. 2018). As a result, LGBTQ individuals are also disproportionately burdened by abortion care coverage limits in Medicaid.

3. Louisiana bans abortion coverage through its state health exchange and Medicaid insurance programs.

Today only 15 state Medicaid programs cover abortion care more broadly than is required by the Hyde Amendment (using state-only dollars)—Louisiana is not one of these states. Kaiser Family Foundation, *State Funding of Abortions Under Medicaid as of June 2019*, https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D# (last visited Nov. 25, 2019). Moreover, Louisiana also bans abortion coverage in insurance plans available through the state health exchange under the Affordable Care Act. *See* Guttmacher Inst., *State Facts About Abortion: Louisiana* (Sept. 2019),

https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana. Thus, for many pregnant Louisianans, enrollment in Medicaid or a private health insurance plan does not protect against having to pay for abortion care out-of-pocket.[4]

B. Out-of-pocket costs for abortion services are prohibitively high for poor and low-income people.

Nationwide the mean price of an aspiration abortion in the first trimester is $508 and the mean price for a medication abortion is $535, and the median price for an abortion at 20 weeks is $1,195, meaning a delay can double the cost of the procedure. Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 216-17 (2018), https://www.sciencedirect.com/science/article/pii/S1049386717305364?via%3Dihub. In Louisiana, the average cost of a first-trimester abortion is about $500; a second-trimester abortion is about $850. Lift Louisiana, Abortion Information and Resources, https://liftlouisiana.org/content/abortion-information-and-resources (last visited Nov. 25, 2019). These costs alone pose an enormous barrier for people living in poverty. When clinics are reduced to just a few, or only

[4] In some cases, low-income people in need of abortion care are able to seek and find financial assistance from local abortion funds. A recent study by the NNAF found that the majority of financial assistance provided by such funds is paid to residents of states, like Louisiana, "without expanded Medicaid access to abortion and states that have private insurance restrictions on abortion coverage." Kotting & Ely, *supra*, at 3.

one, in an entire state, the cost barriers can be insurmountable, especially for poor and low-income people who face additional barriers to access.

C. People experiencing intimate partner violence face additional barriers to paying for abortion care out-of-pocket.

Accessing abortion care undetected by an abusive partner is difficult for survivors who must pay out-of-pocket for the abortion procedure. This is because abusive partners commonly limit access to financial resources as a form of control over their partner. Adrienne E. Adams, *Measuring the Effects of Domestic Violence on Women's Financial Well-Being*, CFS Research Brief 2011-5.6, at 1 (2011). Economic control may include threats or stalking at the workplace, severe restriction of the partner's access to money, and sabotaging employment. *See* Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012). In the context of health care, abusive partners may refuse to allow a survivor the funds to cover co-pays or to purchase a prescription. *See* Karen Oehme et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014). These challenges are amplified when medically unnecessary restrictions, like AB 620's admitting privileges, inflate the out-of-pocket costs of abortion care.

D. Ancillary expenses escalate the overall cost of abortion care.

As previously mentioned, the average cost of first-trimester abortion care in Louisiana is about $500 and a second-trimester abortion costs on average about $850. Lift Louisiana, Abortion Information and Resources, https://liftlouisiana.org/content/abortion-information-and-resources. These figures account only for the healthcare service itself—not the attendant costs of travel, overnight stays, childcare, or lost wages incurred by an abortion patient. For a person working full-time earning minimum wage in Louisiana who earns just $1,256 a month, before paying rent, utilities, food, and transportation costs, the out-of-pocket cost for abortion care can be prohibitive. *See* Center for Poverty Research, Univ. of Cal. Davis, *What are the annual earnings for a full-time minimum wage worker?* https://poverty.ucdavis.edu/faq/what-are-annual-earnings-full-time-minimum-wage-worker.

E. In the course of trying to pay for abortion care, poor and low-income pregnant people are forced into untenable situations that cause hardships and worsen financial instability.

In practical terms, Act 620 renders a medical treatment that may be essential to a person's ability to escape intimate partner violence, to protect their own health, or to parent the children they already have so inaccessible and expensive that people will have to incur great hardship to get it. Pregnant people have reported resorting to selling or pawning personal

possessions and taking out exploitative payday or other loans to cover the costs of accessing an abortion. *See* Amanda Dennis et al., *Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-income Women*, 25 J. of Health Care for the Poor and Underserved 1571, 1580-83 (2014). Others have reported cutting back on necessities such as paying rent, buying food, and paying for utilities to pull together the funds to pay for the abortion care, putting them at risk of hunger and homelessness, in addition to financial hardship. *See id.*; Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 412 (2018). In a national survey, 56 percent of respondents said that out-of-pocket costs for abortion represented more than one-third of their monthly personal income. Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues e211 (2014), https://www.ncbi.nlm.nih.gov/pubmed/24630423.

F. Pregnant people are often forced to delay abortion care while they try to pull together the funds to pay for it, which can increase difficulties and risks.

Low-income people are often forced to carry unwanted pregnancies longer and delay abortions while they attempt to pull together the funds to pay for the procedure. *See* Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who*

Obtain Very Early and Second-Trimester Abortions, 12 PLoS One e0169969 (2017); Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173 (2013). Time passes while people work hard to pull together the necessary funds, delaying the abortion until later in the pregnancy, and while the health risks posed by later term abortion are still very low, they are higher than the risks of first-trimester abortion care. *See* Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstet. & Gynecol. 258 (2015). Having to delay may also make the service more difficult to obtain since there are fewer providers for abortions later in pregnancy. *See* Guttmacher Inst., *Later Abortion* (Nov. 2019), https://www.guttmacher.org/evidence-you-can-use/later-abortion (noting that in 2012, only 34 percent of all abortion-providing facilities offered abortions at 20 weeks' gestation and 16 percent did so at 24 weeks).

For people surviving intimate partner violence, policies like Act 620 that unduly burden access to an abortion heighten vulnerability to abuse. *See* Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1 (Sept. 2014) (hereinafter "Roberts et al., *Risk of Violence*"). Remaining pregnant can put an abused person at grave risk; pregnant women experience high rates of intimate partner violence, Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183 (2010). This abuse is often severe, frequently resulting in serious injuries. Julie A. Gazmararian et al.,

Prevalence of Violence Against Pregnant Women, 275 JAMA 1915, 1918 (1996). Homicide is also a risk: abuse victims are three times more likely to be murdered by their abusers when they become pregnant. *See* Merle H. Weiner, *A Parent-Partner Status for American Family Law* 331-32 (2015). African American women and very young women are most likely to be murdered during pregnancy. Jeani Chang et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999*, 95 Am. J. Pub. Health 471, 473 (2005). These particular hardships for survivors of intimate partner violence are part of the bigger picture of numerous risks people suffer when they are forced to carry an unwanted pregnancy to term.

III. There are grave risks and long-lasting repercussions for Louisianans who will be unable to obtain the abortion care they need if Act 620 is allowed to go into effect.

Act 620 will reduce the already low number of abortion providers in Louisiana, further limiting access to abortion care. This will lengthen delays and ultimately result in the denial of care for poor and low-income Louisianans, who struggle the most to afford abortion care. Being forced to carry a pregnancy to term can prolong or worsen poverty, and, given the inherent risks of childbirth and the unique dangers for survivors of intimate partner violence, it may well threaten the pregnant person's life and well-being.

A. Quite often people are unable to pull together the necessary funds to pay for abortion care in time and must, therefore, carry a pregnancy to term.

One study determined that, on average, one in four low-income people are forced to carry an unintended pregnancy to term who would have instead accessed abortion if they could afford to do so. Stanley K. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortion: A Literature Review* (2009). As a result of the aforementioned delays, low-income pregnant people are also more likely to be denied abortion services altogether due to gestational limits or other restrictions. Nationally, researchers estimate that over 4,000 pregnant people each year are unable to obtain an abortion due to gestational limits. Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (2014). Louisiana generally does not permit abortions after 20 weeks; pregnant people who delay abortion to save funds are likely to be denied outright after that point. *See* Guttmacher Inst., *State Bans on Abortion Throughout Pregnancy* (Nov. 1, 2019), https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions.

B. The economic impacts of people not being able to obtain the abortion care they need are significant and long lasting.

Pregnant people who seek but are unable to obtain abortion care are significantly more likely to experience long-term poverty than their peers who were able to receive the abortion care sought. *See* Foster et al., *supra*, 108 Am. J. Pub. Health at 412. Ensuring abortion access enables people who access the service to aspire to and achieve goals related to education, employment, and change in residence. *See* Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (Nov. 2015), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1. This economic impact is compounded by the health risks of carrying an unintended pregnancy to term.

C. Carrying a pregnancy to term involves serious physical risks that disproportionately impact people of color and survivors of intimate partner violence.

1. Mortality rates are far higher with childbirth than with abortion.

The risk of death associated with carrying a pregnancy to term is, on average, approximately 14 times higher than that with abortion. *See* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United*

States, 119 Obstet. & Gynecol. 215 (2012). In a recent study comparing patients who received an abortion with those who were denied an abortion, potentially life-threatening complications, such as eclampsia and postpartum hemorrhage, were only experienced by the group denied abortions and forced to carry the pregnancies to term. One woman in the study who had been denied an abortion died from a condition known to be more likely fatal for pregnant people, illustrating the increased risk of death faced by pregnant people unable to access abortion care. *See* Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women's Health Issues 55, 57 (2016).

2. People of color in Louisiana and nationwide are more likely to die from pregnancy- and childbirth-related conditions than their white peers.

Furthermore, maternal mortality risks disproportionately impact people of color. *See* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215 (2012). It is a national shame that the risk of death from childbirth for African Americans is significantly higher than that of white people. *See* Sarah J. Holdt Somer et al., *Epidemiology of Racial/Ethnic Disparities in Severe Maternal Morbidity and Mortality*, 41 Sem. in Perinatology 258 (2017) (noting that in the U.S. racial and ethnic

disparities in maternal mortality are extreme); Cynthia Prather et al., *The Impact of Racism on the Sexual and Reproductive Health of African American Women*, 25 J. Women's Health 664 (2016) (stating that black women are three to four times more likely to die from pregnancy-related complications than white women). And, the mortality rate among African Americans giving birth in Louisiana is even higher than the national average with 112.2 per 100,000 live births in the state, as compared with 63.8 per 100,000 live births nationally. Maternal mortality rates for African Americans in Louisiana soar over the overall national average of 29.6 deaths per 100,000 live births. *See* United Health Foundation, *America's Health Rankings* (2019), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/population/maternal_mortality_a_black/state/LA. From 2011 to 2016, black women were 4.1 times more likely to die from pregnancy-related causes compared with white women in Louisiana. Lyn Kieltyka et al., *Louisiana Maternal Mortality Review Report 2011-2016*, at 22 (Aug. 2018), http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/maternal/2011-2016_MMR_Report_FINAL.pdf. Act 620 would exacerbate existing health disparities without providing any health benefits.

3. Carrying a pregnancy to term often exposes people experiencing intimate partner violence to more abuse.

As previously discussed, survivors of intimate partner violence are more likely to need abortion care. *See* Megan Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, 11 PLoS Med e1001581 (2014). They risk remaining trapped in violent relationships if they are unable to access abortions when they seek them. *See* Roberts, *Risk of Violence* (between six and 22 percent of people seeking abortion report recent violence from an intimate partner). Research demonstrates that for people in abusive relationships who sought abortions but were denied them, having a baby with the abuser appears to result in ongoing violence, measured over the course of two and one-half years after the pregnancy. *Id.* at 2, 5. Conversely, "having an abortion was associated in a reduction over time in physical violence" from the abuser involved in the pregnancy. *Id.* at 5. As these statistics demonstrate, laws like Act 620 that drive up costs, force delays, and ultimately bar people from obtaining abortion care not only rob pregnant people of agency in their reproductive lives but also expose them to real risk of immediate and ongoing harm.

CONCLUSION

Upholding the Fifth Circuit's decision and permitting Louisiana to enforce Act 620 will decimate the number of abortion providers in the state and severely restrict access, thereby increasing hardships for poor people who struggle to pay for abortion care

and prolonging poverty and exposure to abuse while exacerbating the risks of serious injury and death for those who are denied the abortion care they need. For the foregoing reasons, *amici curiae* respectfully request this Court to reverse the decision below.

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